St. Mary's Hospital  St. Mary's House's Hospital  St. Mary's House's House	3, 2005 9:00 A  County of Death  L. Mary's  9. Birthplace (State or Foreign Country)
St. Mary's Hospital  St. Mary's Hour's Man Hour's H	County of Death  L. Marys  9. Birthplace (State or Foreit Country)  Maryland  10d. Inside City Limit
Social Security Number   Social Security Num	9. Birthplace (State or Forei Country) Maryland  10d. Inside City Limit
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10a. State 10b. County 10c. City, Town or Location 10b. City 10c. City, Town or Location 10c. City Town or Location 10c. City Town or Location 11c. City Code 10c. City Town or Location 11c. City Code 11c. City, Town or Location 11c. City Code 11c. City, Town or Location 11c. City Code 11c. City, Town or Location 11c. City Code 11c	10d. Inside City Limit
Elementary/Secondary (0-12)  Below B	1∑Yes 2□N
Elementary/Secondary (0-12)  Below the policy of the polic	zen of What Country?
Elementary/Secondary (0-12)  Below the post of the pos	5A 14. Race - American Indian, Black, White, etc. Specify: White
Louis Henry Cargill    Page 1   Page 2   Page 3   Page 3	nd of Business/Industry
1	Lucas
21. Signature of Funeral Service Lornsea  22. Name and Address of Facility  Mattingley-Gardiner Funeral Home. P.A	88 cation - City or Town, State
P.O. Box 270, Leonardtown, Maryland 2	inza, Maryland
Physician // Medical Examiner  Page 1: 19	Approximate Interval Between Onset and Death
FFEMALE: 23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic pregnancy   23b. Was decedent pregnant   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   Ves   2	3d. Date of delivery Month Day Year
Part II. Other significant continuous contributing to death but not resulting in the underlying cause given in Part I.	se contribute to the cause of death?
A S C C C C C C C C C C C C C C C C C C	24b. Were autopsy findings availate prior to completion of cause of death? 1 □ Yes 2 □ √No
1  Yes 2  No	
building, etc. (Specify)  City or Town, State)	Number or Rural Route Number,
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date	and manner as stated. place, and due to the cause(s)
29b. Signature and title of certifier  29c. License number  29d. Date	signed (Month, Day, Year)
30. Name an a.dr. ss. person who completed cause of death (Item 23a) (Type, Print)  Rakhi Krishnan, M.D. 26840 Point Lookout Road, Suite 101, Leonardtown, Maryland 2  State Registrar  Registrar  31. Date filed (Mcnith, Day Year)  2 1 2005	

	1- State Unpend Item 23a&27 per	aryland Depa me 6850 1 Ce	artment of Health and rtificate of Death	Mental Hygie	
Physician /Medical	Decedent's Name (First, Middle, Last)     EDWARD WILLIAM  4a. Facility Name (If not institution, give street and number)	LAVINE	4b. City, Town, or Location of Dea	2 Date of Death Month NOVEMBER	Day Year 3. Time of Death 22, 2005 9:45 A.
Examiner Funeral	8819 GREEN VALLEY ROAD	e (In yrs. last birthday)	LIBERTYTOWN  If Under 1 Year   If Under 24 Hr	8. Date of Birth	FREDERICK  9. Birthplace (State or Foundation)
Director	145-34-9697 Usual Residence of Decedent	60 Yrs.	Months Days Hours Mir	OCT. 25,	1945 New York
with the Marylau s or 28s-1 show be notilied at	10a. State 10b. County Maryland Frederick	10c. City, Town or Lo	tytown		10d. Inside City Lin 1 ☐ Yes 2X
th with the 23a or 2	10e. Street and Number 8819 Green Valley Road		10f. Zip Code 21762		. Citizen of What Country? United States
s 1 end 2 should be filed within 72 hours after deeth with the Maryland is 1 end 2 should be filed within 72 hours after deeth with the Maryland item 27 is marked other than "naturel", or items 23s or 28s-f show other treumatic event, the Madical Examinat must be notified at To Be Completed by Funeral Director	11. Maritaf Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Armed Forces?  1 Yes, Give Year or Dates:	No	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
d 2 should be filed within 72 hours aft hand Mental Hygiene. The marked other than "naturel", or treumatic event, the Madical Example To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5	(Give	dent's Usual Occupation kind of work done during most of wi DO NOT use retired)  motive Instructo	orking	b. Kind of Business/Industry
12 should be filed whand Mental Hygies 7 is marked other treumatic event, the To Be Col	17. Father's Name (First, Middle, Last)  Edward W.	Lavine	<del></del>	me (First, Middle, Ma	
d 2 sho ith and P 27 is ma treuma	19a. Informant's Name/Relationship (Type, Print)  M. Eileen Lavine / Wife		ng Address <i>(Street and Number or F</i> Green Valley Rd		
or other	20a. Method of Disposition  1 🔀 Burial 2 Cremation 3 Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place)	Date 200	c. Location - City or Town, State
permit. Pages 1 end 2 Depertment of Health a Importent: if Item 27 it any injury or other tre once.	4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee	2:		auffer Fur	ederick, Maryland neral Homes, P.A.
State be executed hypotecian and the burial-transit the burial-transit dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	a consequence of):  a consequence of):  a consequence of):	ardiovascular di	sease	
Attending Physician: The law requires thet the death certificate be death.  Sector: After this certificete has been signed by the attending physicia py the funeral director, page 2 should be detached for use as the built cation; To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
quires that an signed to and be deta	Part II. Other significant conditions contributing to death b	ut not resulting in the u	nderlying cause given in Part I.		cco use contribute to the cause of death?
ician: The law requir certificete has been s ector, page 2 should Be Completed				24a. Was an autopsy performed Yes 2	
ath. r: After this certifice funeral director, afton: To Be e	25. Was case referred to medical examiner?  1 XYes 2 No  27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation  28a. Date of Injunction (Month, Date of Injunction)		nt 3 DOA Other: 4 Nursing	eath (Check only one)  Home 5 Residence  28d. Describe how	e 6 XOther (Specify) SCENE injury occurred
To the Hospitel or Attending F within 24 hours effer death. To the Funeral Director; After completely filled in by the funeral Medical Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injuding, etc.	ury - At home, farm, sti c. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
he Hosp in 24 hou he Fune pletely fill edical	29a. Certifier Cineck only one  Medical Examiner: On the basis of and manner sta	examination and/or in	h occurred at the time, date and plac vestigation, in my opinion, death occ	e, and due to the caus urred at the time, date	e(s) and manner as stated, and place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier		O.C.M.E.		Date signed (Month, Day, Year) VEMBER 23,2005
	30. Name and address of person who completed cause o	eath (Item 23a) (Type,	Print)	BALTIMORE	escentera por caso cara.
State Registrar		ar's Signature	Coast .		

			For Stata Registrar	State of M	•	partment of ertificate o		d Mental Hy	giene Reg. No.	005	39003
	Physici		1. Decedent's Name (First, Middle, Last) Berdine Cu	stis	L	ewis		2. Date of Dea Novembe		, 2005	3. Time of Death 7:58Р. м
	/Medic Examin	er	4a. Facility Name (If not institution, give s Rockville Nursing	treet and number) Home			, or Location of D Ville			County of Death Montgome	
	Funeral Director			M 2(X) F 7. Ag	e (In yrs. last birthda 94 Yrs			Hrs. 8. Date of Birt Min. (Month, Da March3	y, Year) 191:	9. Birth Coul Virg	place (State or Foreign ntry) Sinia
Maryland	if show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgome	ry	10c. City, Town or Rockvil						10d. Inside City Limits 1
h with the	23a or 28e ist be not	Funeral Director	303 Adclare Road			10f. Zip Code	0850			ted Stat	
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show importent: If item 27 is marked other than "naturel", or iteme 23a or 28a-f show once. once.	Ď	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1  Yes 2 1 If Yes, Give Year or Dates:	Ever in U.S. 1	3. Was Decedent of If Yes, specify Cu		? (Specify Yes or No- uerto Rican, etc.)		4. Race - Americ Black, White, Specify:	
<b>21215-0036</b> ad within 72 hours aft	giene. er than "natu , the Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0,12)		(G.	cedent's Usual Occive kind of work done.  DO NOT use reti	cupation ne during most of ired)	working		nd of Business/In	
Maryland	Aental Hy rked oth tic event	To Be (	17. Father's Name (First, Middle, Last) Franklin Augustus	Lewis				Name <i>(First, Middl</i> e, : Geneva R		,	
Mary nd 2 sho	alth and N 27 is ma r treuma		19a. Informant's Name/Relationship (Ty) Patricia E. Long-B	oe, Print) radley/ni	iece P.C	ailing Address (Stre	et and Number of B Huntin	gtown, Mai	er, City or cylar	Town, State, Zip nd 20639	c Code)
Baltimore,	nent of Hea int: If item iry or othe		20a. Method of Disposition  1 Burial 24 Cremation 3 R.  4 Donation 5 Other (Specify)	amoval from State	cemetery of	sposition (Name of trematory or other p Litan Cre	matory 1	Date 1/28/2005		ation - City or To	own, State Virginia
Balti permit.	Departm Importe any inju once.		21. Signature of Funeral Service Libense	anto		Darlandowd 4400 Fowd	<sup>re</sup> Borgwar er Mill	dt Funera Road Belt	l Hon	me, PA le, Mary	land 20705
Ex.	ysician and physician and street prices is the burial-transit	dical Examiner	23a. Part I. Ent. The disease, or complishood of heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Dehydra Due to (or as Dehydra Due to (or as Polyart	ne. nia a consequence of):	30	ying, such as can	uiac di Tespiratory ar	rest,		Approximate Interval Between Onset and Death
I Records, P.O. Box 68760,  The law requires that the death certificate be executed	ed by the attending ph detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic pregnar 5 □ Other (specify)	ncy		2	3d. Date of delive	ery Day Year
rds, P	D eg	þ	Part II. Other significant conditions con Hepatitis B	tributing to death b	ut not resulting in the	o underlying cause o	given in Part I.		obacco us /es 2	-	he cause of death?
	certificate has been si rector, page 2 should	Completed								prior to co death?	psy findings available mpletion of cause of
on of	n. After this funeral di	ıtlon: To Be	25. Was case referred to medical examiner?  1  Yes	ospital: 1 Inpatie 28a. Date of Inju (Month, Da	ent 2 ER/Outpa iny 28b. Time y Year) Injur	e of 28c. In	other: 4 Nursin	Death (Check only only only only only only only only	lence 6		jy)
Division of or Attending	affer death. I Director; A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury - At home, farm, c. (Specify)	street, factory, office	е	28f. Location (S City or Ton		Number or Rura	al Route Number,
Div To the Hospitel or	within 24 hours affer deatl  To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  Certifying Physics 2 Medical Examination	ician: To the best er: On the basis o and manner st	f examination and/or	eath occurred at the investigation, in my	time, date and pl opinion, death o	ace, and due to the occurred at the time, o	cause(s) a date and p	and manner as si place, and due to	tated. the cause(s)
Toth	withii To the	Me	29b. Signature and title of certifier	eki		29c. Lices D27	nse number 830			signed (Month, nber 28,	
	5		30. Name and address of person who co Ramleth T. Shakir,	mpleted cause of o	leath (Item 23a) (Typ Shady Gr	oe, Print) Cove Court	t Gaithe	rsburg, Ma	aryla	and 2087	7
,	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 2 20		ar's Signature						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Robert William Myles, Sr. 1, 2005 16:50 p<sup>M</sup> November /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1811 64th Avenue Prince George Cheverly If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 229-36-3413 72 Director Feb. 18, 1933Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits d other then "naturel", or iteme 23a or 28a-f ehow event, Ir e Medical Examiner must be notified at 1X Yes 2 No Directo Maryland Prince George Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1811 64th Avenue 20785 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Pages 1 and 2 should be filed within 72 hours after timent of Health and Mental Hygiene. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Receiving Dept. Manager <u>Private</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Myles Elizabeth Shepherd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17318 Brook Meadow Lane Upper Marlboro, MD 20772 Devona Myles / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Pag Department Importent: Il any injury o 1 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 11/11/05 Alexandria, Virginia 21. Signature of Funeral Service/Licensee 22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlhoro Pike Forestville, 6 Part 1. En ler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one a use on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Suse (Final disease or condition resulting in death) Atheroscheretiz Cardiovascular Hea Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1 ☐ Yes 2X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 TResidence 6 Other (Specify) 1 XYes 2 ☐ No Certification: To

After or Attending hours after death unerel Director: the filled in by the Hospitel

within 24 hours a

State Registrar

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

5 Pending

investigation

6 Could not be determined

27. Manner of Death 1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

(Check only

29b. Signature and title of certifier

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 ☐ Yes 2 ☐ No

HO053927

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#23a, PI pen F 9854 4/27/06 TT Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer Lorenzo Miller, Jr. November 2005 2:45P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George Hospital Cheverly Prince George If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1KIM 2□ F 579-48-1237 71 Yrs Dec.24, Virginia Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1基 Yes 2 □ No D. C. N/A Washington, D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 730 46th Street, SE. 20019 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1956— If Yes, Give Year or Dates: 1958 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 28 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Property Manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lorenzo Miller, Sr. Alice Ross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 730 46th Street SE; Washington, D.C. Rita Miller/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Fort Lincoln Cemetery Nov. 11, 2005 1 4 □ Donation 5 □ Other (Specify) Brentwood, MD. 21. Signature of Funeral Service Licen 22. Name and Address of Facility Pope Funeral Homes 5538 Marlboro Pike Forestville, MD. 20747 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Blunt chest injuries with complications Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, name cause to name data cause. Enter Underlying Cause (Disease or injury Use to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. Il yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CANTIEVASCULON HEART 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Compole Injury 1 Nateral 5 Pending Otober 14,200 STruck utility 1 ☐ Yes 2 ☐ No unK investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 3 Suicide 28l. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide SILECT

Examiner The law requires that the death certificate be executed attending physician and Division of Vital Records, P.O. Box 68760. Director:

Examiner Physician/Medical Be Completed by Hospitel or Attending Physician: filled in by within 24 hours after To the Funerel Direct

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

or 28e-f show

23a

permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Menial Hygiene. If them 27 is marked other then "natural", or items: any injury or other treumatic event, the Medical Experimentations.

Physician /Medical

Baltimore, Maryland 21215-0036

The Medical Examinar must be notified at

Director

Funeral

ģ

Completed

State

Certification: To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and ode to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation 29a. Certifier Medical completely (Chack only one) 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

20005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001 HOS er. 31. Date liled (Month, Day, Year) NOV 1 6 2005

2. Registrar's Signature

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 9, Deborah I. Miggins November 2005 20:42 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Fort Washington Prince Georges Fort Washington Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 27, 6. Sex 9. Birthplace (State or Foreign 1□M 25 F Months Days Hours Yrs. 87 1918 025-16-4485 ΜÁ

10d. Inside City Limits

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

Private

United States

Race - American Indian, Black, White, etc.

**Black** 

1 Syes 2 □ No

20602

Suite #207, Waldorf, Md.

10c. City, Town or Location

Fort Washington

10f. Zip Code

**Funeral** Director

**Physician** 

/Medical

Examiner

Usuel Residence of Decedent

10b. County

PC

10a Stete

Md. 10e. Street and Number

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If them 27 is marked other than "natural, or items 23s or 28s-f ahow item 27 is marked other than "natural", or items 23a or 28a-f show other traumstic event, the Medical Examiner must be not find at

physician and s the burial-transit Division of Vital Records, P.O. Box 68760, signed by the a d be detached f r death. Š

12110 Donnybrook Drive 20774 Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🔯 No If Yes Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16a, Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4or 5+) 12 Medical Assistant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) å George C. Miggins Pearl C. Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12110 Donnybrook Drive
Fort Washington, Md. 20744 19e. Informant's Name/Relationship (Type, Print) Department of Health a important: If Item 27 is any injury or other tra Rev. Wayne P. Miggins/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Physician Immediate Cause (Final disease or condition resulting in death) Veccal **Examiner** Due to (or as a consequence of) Examine or Attending Physician: Tha law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as a consequence of): Physician/Medical Due to (or as e consequence of) resulting in death) Last Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. ģ Completed 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient P 1 ☐ Yes 2 ☑ No 2 X ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled in Medical 29a. Certifier (Check only one)

20c. Location - City or Town, State Acushnet Cemetery Corp. 11/17/05 Acushnet, MA 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1. TYES 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Year)

Louis

NOV 1 6 2005

Kaufman,

**DHMH 16 Rev 6/95** 

12070 Old Line Centre

ho completed cause of death (Item 23a) (Type, Print)

			1 _ For State	State of Mary	land / D	epartm		lealth and	•	2000	20007
			Ragistrar	-41		Certinic	tale of I	Jeam	2. Date of De	Reg. No. UU	07001
	Physicia	an	Decedent's Name (First, Middle, La						Month	eath Day Ye	
	/Medic	al	Paul "	Bernard			rris,	Sr. Location of De	Novemb	er 15, 200	
•	Examin	er	4a. Facility Name (If not institution, giv	e street and number)					am	4c. County of D	eatn
_			Mercy Hospital  5. Social Security Number 6.5	Sex 7. Age (Ir	yrs. last birti		Baltimo	re If Under 24 H	rs. 8. Date of Bi	rth 9	Birtholace /State or Foreign
	Funeral Director			NOW 2□F	•		nths Days	Hours Mi	n. (Month, D.	ay, Year)	Birthplace (State or Foreign Country)  New Jersey
-			Usual Residence of Decedent		<u> </u>				TYOVEILD	er 20,193(	New Jersey
	nylan how		10a. State 10b. County	10	c. City, Town	or Location	1				10d. Inside City Limits
	B Ma	cto	DC		Washir	igton,	D.C.				1 X Yes 2 □ No
	or 28	Oire	10e. Street and Number			10	f. Zip Cod <i>e</i>			10g. Citizen of What	t Country?
	death with the Maryland rms 23e or 28a-f show	Funeral Director	1323 S Street, S				20020			USA	
	er de	une	11. Marital Status	12. Was Decedent Ever Armed Forces?		13. Was D	ecedent of H specify Cuba	ispanic Origin? ın, Mexican, Pu	(Specify Yes or Ne erto Rican, etc.)	0- 14. Race - A Black, V	American Indian, Vhite, etc.
2	rs aft	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give Year or Dates:	53	1 □ Y	es 2 X No	Specify:		Specify: W	hite
3-003g	tura stura		15. Decedent's E			Decedent's	Usual Occup	ation		16b. Kind of Busine	ess/Industry
2	n "n	plet	(Specify only highest gr. Elementary/Secondary (0-12)			(Give kind o	of work done of OT use retired	during most of w	vorking	D.C. Gov	•
7	d with giene ar tha	Completed	12	College (1-401 3+)	For	eman				WASA	CITIMONE
2	be filed within 72 hours after death with the Marylan ital Hygiene.  Identify than "natural", or Items 23e or 28e-f show other than "natural", or Items 23e or 28e-f show seent, the Medical Evaninatinatinal Experiment	Bec	17. Father's Name (First, Middle, Last	)				18. Mother's N	lame (First, Middle	, Maiden Sumame)	
/Idina	uld b Ments rrked rrked	Tof	Paul		McNorr	is		Viola		A1c	hu
0	2 should be and Menta is marked eumatic sv	Ė	19a. Informant's Name/Relationship	Type, Print)	19b.	Mailing Add	dress (Street	and Number or	Rural Route Numb	oer, City or Town, Stat	re, Zip Code)
≥ ນົ	s 1 and 2 should if Health and Mer item 27 is marke ofther treumatic		Rose Marie McNor					.,Washi	ngton,DC		
	Pages 1 nent of H int: If ive		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	I	20b. Place of cemeter	Disposition v. crematory	(Name of or other plac	e)	Date	20c. Location - City	or Town, State
Dalilli	permit. Pages Department of Important: If i any injury or once.		*4 □Donation 5 □ Other (Speci		Kalas				16,2005	Edgewater	, MD
<u> </u>	permil Depar Impor any ir		21. Signature of uneral Service Line	psee		Geor Geor	ge P.	s of Facility Kalas F	uneral H	ome, P.A. Hill, MD 2	
	40200		23a. Rint. Ener the disease, or com	nplications that caused the	death Don	6160	Oxon	Hill Rd	., Oxon l	Hill. MD 2	0745 Approximate
			shock, or heart failure. List only	one cause on each line.			mode or dyin	g, such as card	iac or respiratory a	111 <del>0</del> 51,	Interval Between Onset and Death
L	Physician   /Medical		Immediate Cause (Final disease or condition resulting in death)	Sepsis Sy							1 day
	Examiner			Due to (or as a co	onsequence o	π):					
L		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a co	onsequence o	of):					
	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease of injury) that initiated events	C							
ĵ	an ar		resulting in death) Last	Due to (or as a co	onsequence o	of):					
2/00	e ys	Ical		d							
ŏ	certificate Iding phys	Med	IF FEMALE:								
X00	death ce e attend ed for us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death		pic pregnancy			23d. Date of Month	delivery Day Year
5	that the death certifica ed by the attending ph detached for use as th	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time 9 ☐ Unknown	e of death	5 ∐ Othe	er (specify)				,
ŗ	that ti		Part II. Dther significant conditions	contributing to death but ne	ot resulting in	the underly	ing cause give	en in Part I.	23e. Did	tobacco use contribut	e to the cause of death?
ecords,	The law requires that the site has been signed by the bage 2 should be detache	d by	End Stage Renal	Failure, Chr	onic R	espir	atory	Failure	. 10	Yes 2□No 3□	Probably 4 XUnknown
5	w req beer shou	Completed	Peripheral Vascu						24a. Was	an 24h Were	autopsy findings available
ב	: The law cate has b	mo							auto	prior prior deatl	to completion of cause of
VII		e Cc	25. Was case referred to medical					26 Place of D	1 ☐ Yes		fes 2□No
	ysicien: is certific director,	o B	examiner? 1 ☐ Yes 2 👿 No	Hospital: 1  Inpatient	2 ER/Out	patient 3	DOA Othe	0.5		idence 6 Other (S	Specify)
5	ding Phys h. After this funeral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Ye			28c. Injun Worl			how injury occurred	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
SIOIS	Attending Physicien: r death. ector: After this certific: by the funeral director.	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	in		M		Yes 2 □ No			
<u>"</u>		ertification:	3 Suicide 6 Could not be determined		At home, far	m, street, fa	actory, office			(Street and Number of	Rural Route Number,
2	spitel or ours afte nerel Dir filled in	O									
	To the Hospitel or within 24 hours after To the Funerel Diractory completely filled in I	edical	(Check only 2 Medical Exa	hysician: To the best of m miner: On the basis of exa	amination and						
	To the Hos within 24 h To the Fur completely	Med	one)  29b. Signature and title of certifier	and manner stated			29c. License	number		29d. Date signed (M	onth, Day, Year)
	To To com			- ( not A A	10		DL	171	30)	Novis	-
)	(10)		30. Name and address of person who	completed source of death	(Itam 22=) 5	Tune Dring	J'	100	- 1	140 V./-	12000
			Joseph Costa, M.					, MD 21	202		
	Sta	te	31. Date filed (Month, Day, Year)	3 Registrar's	Signature			,			
	Registr	ar ·	NOV 1 6 200	15 Kenne	K	hall.	,				

# WILBUR R. MCCOY, JR. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Physicia	n	<ol> <li>Decedent's Name (First, Middle, Last)</li> </ol>		McCoy, J	r.			2. Date of D NOVEMB		. 2005	3. Time of Death
/Medica Examine	r	4a. Facility Name (If not institution, give a	street and number)				ocation of De		4c. (	County of Deal	th
Funeral Director		5. Social Security Number 6. Sep. 579-56-9338	7. Age (In y	rs. last birthday) Yrs.	If Under Months		If Under 24 H	8. Date of B lin. Octobe	irth ay. Year) 20,	9. 8in 1945 W	thplace (State or Foreign puntry) Vashington D
ed at		Usual Residence of Decedent  10a. State 10b. County  Laryland Prince Ge		City, Town or Lo		Movell					10d. Inside City Limits 1 ☑¥es 2 ☐ No
with the N a or 28e-f	Direc	10e. Street and Number 10247 Prince Pla			Ipper	Code	774		10g. Citiz	en of What Co	
	by Funeral		12. Was Decedent Ever in Armed Forces?	1966	Was Deced If Yes, spec	dent of His only Cuban	panic Origin?	(Specify Yes or Nierto Rican, etc.)		4. Race - Ame Black, Whit	
vithin 72 hou ne. han "nature e Madical E	Completed	15. Decedent's Edu (Specify only highest gradi Elementary/Secondary (0-12)	cation	16a. Dece (Give life.		rk doné du se retired)	uring most of	working	16b. Kin	d of Business	
d be filed varial Hygie ced other t	e Q	12th 17. Father's Name (First, Middle, Last) Wilbur R. McCoy,	Sr		Lette		18. Mother's I	Name (First, Middle	e, Maiden S	OVEYNME Gumame)	nt
id 2 should th and Me 17 is mark traumation	0	19a. Informant's Name/Relationship (Ty					nd Number or	gnes Thor Rural Route Numi W, Washir	per, City or		
Pages 1 an ent of Heal at: If Item 2 ry or other		20a. Method of Disposition  1 Surial 2 Cremation 3 A 4 Donation 5 Other (Specify)	emoval from State	p. Place of Dispo cemetery, crei	sition (Nam matory or o	ne of ther place)	)	Date /30/2005	20c. Loc	ation - City or eltenha	Town, State
permit. F Depertm Importer eny injur	Ī	21. Signature of Funeral Service Licens		2:	2. Name an	d Address	of FacilityL		unera	l Serv	rices, P.A.
Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the die cause on each line.  Complicat  Due to (or as a cons	ions of			, such as card	liac or respiratory	arrest,		Approximate Interval Between Onset and Death
	EXa	Sequentially list conditions, and the same districtions of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	uence of							
that the death certificate ed by the attending phys detached for use as the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	3c. If yes, outcome of pre- 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pro				23	3d. Date of del Month	ivery Day Year
quires that in signed b		Part II. Other significant conditions cor	ntnbuting to death but not	resulting in the u	nderlying ca	ause given	n in Part I.				o the cause of death?
cete has been si	Completed					_		24a. Wa auto perf 17 Yes		24b. Were au prior to death? 1 Ø es	atopsy findings available completion of cause of 2 No
ig Physi ter this o	0	25. Was case referred to medical examiner?  12. Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year) 28e. Place of Injury - A building, etc. (Spe	t home, farm, str	f 21	8c. Injury a Work?	4 ☐ Nursin	Death Check on y g Home 5 Res 28d. Describe 28f. Location City or Tr	idence 6 how injury	occurred	cify) ural Route Number,
To the Hospitel or Attendin within 24 hours eiter death. To the Funerel Director: At completely filled in by the fun		(Check only 2   YMedical Examil	sician: To the best of my liter: On the basis of exam	knowledge, deat	h occurred a	at the time	, date and planton, death or	ace, and due to the	cause(s) a	nd manner as	stated.
thin the mple	Medical	one) 21 29b. Signature and title of certifier	and manner stated.		29c	. License r	number		29d. Date	signed (Monti	h, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician NOVEMBER 13,2005 Par MARTHA MAY MAICHLE 21:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 63 HACKS POINT ROAD EARLEVILLE CECIL Months Days Hours Min. DECEMBER 19, 1939 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2∏F 213-38-7139 65 PΑ Yrs. Director Usual Residence of Decedent the Maryland show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at MD CECIL EARLEVILLE 1 ☐ Yes 2 No Director or 28e-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 63 HACKS POINT ROAD 21919 naturel', or items 23a USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mentai Hygiene. Importent: if Item 27 is marked other than "naturel", or Item any injury or other treumatic svent, the Medical Examples 2008. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No WHITE Specify: Specify: ۾ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HEALTHCARE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be AUBRY VINCENT EVELYN MAE HICKEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN MAICHLE/HUSBAND 63 HACKS POINT ROAD, EARLEVILLE, MD 21919 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State DELAWARE VETERANS NOV.16,2005 BEAR, DELAWARE \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM
130 SPEER ROAD, CHESTERTOWN, FUNERAL HOME, P.A. MD 21620 Luk 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 attending physician as the IF FEMALE esn 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Munknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate Division of Vital 1 Yes 2 A NO 1 Yes 2□ No Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 1 ☐ Yes 2 ☐ №6 ٩ 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Pesidence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 | Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7 and address of person who completed cause of geath (Item 23a) (Type, Pngt) PATELMI) 31. Date filed (Month. Day, Year) 32. Registra s Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 10, 2005 **Physician** MILDRED CULVER MCDANOLDS 18:28 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER RIVER MANOR CHESTERTOWN KENT If Under 1 Year | If Under 24 Hrs. | Months Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) SEPTEMBER4, 1915 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F 90 214-60-9591 Director NJ Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23s or 28e-f show the Medical Evantiner must be notified at KENT Be Completed by Funeral Director CHESTERTOWN 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 MORGNEC ROAD 21620 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene Important: If Item 27 is marked other than "ns any injury or other treumatic event, Tet Media 0008. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CLARENCE CULVER CORA LOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM R. MCDANOLDS/SON 12807 STILL POND ROAD, STILL POND, MD 21667 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State SHREWSBURY CEMETERY NOV.14,2005 KENNEDYVILLE, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 130 SPEER ROAD, CHESTERTOWN, MD 21620 Krik 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the To the Hospital or Attenwithin 24 hours after deat To the Funerel Director: 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 123889 11/14/05 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) St CHester town Med, 21620 223 High TOLNE. ARRHBAL u.D. 1 5 2005 Registrar's Signature 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State Ragistrar	State of Man		artment of H			ene 005	39011
Discorde		1. Decedent's Name (First, Middle, La	st)				2. Date of Death Month		3. Time of Death
Physic /Med		MARY LI	IIIAN M.	MC	ORE		NOVEMBER	Day Yes	14
Exami		4a. Facility Name (If not institution, given	e street and number)		4b. City, Town, or	Location of Death		4c. County of D	
		FRIENDS NURSI			SANDY S		T	MONTGO	
Funeral			Sex 7.Age (/. I□M 2)ATF	n yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear)	Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent				l	Aug. 18	1915	Georgia
ylano		10a. State 10b. County	10	c. City, Town or La	ocation				10d. Inside City Limits
Mar Ba-f sl	ctor	Md. Mont	gomery	Sandy	Spring				1 ☐ Yes 2 🗖 No
ih the	Director	10e. Street and Number	_		10f. Zip Code			g. Citizen of What	
death with the Maryland rms 23a or 28a-f show rmust be notified at	ral	16700 Norwood				20860		United S	tates
er de	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
rs aft	by F	1 ☐ Never Married 25 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗷 No	Specify:		Specify:	White
hours a stural', c	pa	15. Decedent's E		16a, Dece	dent's Usual Occupa	ation	11	6b. Kind of Busine	es/Industry
nin 72 in "ni	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed)  College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of world)	king		ow meastry
d with giene er the	E	12	4	Te	acher			School	S
be filed within 72 hours after tal Hygiene, dother than "natural", or its event, the Medical Examina.	Be	17. Father's Name (First, Middle, Last					e (First, Middle, Ma	aiden Surname)	
should b and Ment marked umatic	10	John Murphe	У			Ina	Chance		
2 shc and is m		19a. Informant's Name/Relationship	Type, Print)		ng Address (Street a			-	
and lealth m 27 her tr	L	S. Brook Moore			00 Norwoo				
bernil. Pages 1 Deportment of H mportant: if ite iny injury or off		20a. Method of Disposition 1 Burial 2 Cremation 3			matory or other plac	θ)		Oc. Location - City	
timen tant:		`4 ☐ Donation 5 ☐ Other (Speci			itan Crem		15/05	Alexandr	ia, Va.
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryian Department of Health and Montal Hygiene. Important: If Item 27 is marked other than "natural; or itams 23a or 28a-f show any njury or other treumatic event, the Medical Example must be political at once.		21. Signature of Funeral Service Lice	d/ Q	1 - 2:	2. Name and Addres Muriel H		Funeral	Home	
40260		neweg	W. Beer	vec 1	P. O. P	lox 5038,	Laytonsv	ille, Md	
		23a. Part1. Enter the disease, * con shock, or heart failure. List only	one cause on each line.	death. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arres	it,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 1740 C6	whial	intar	SIN			10min
Examiner		1	Due to or as a co	onsequence of):	. 60.	0	,		40
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of):	urm	) and	auc		TO YEAR
uted ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
exec in and ial-tra	Exa	resulting in death) Last	Due to (or as a co	onsequence of):					
icate be executed physician and sthe burial-transit	dical		d						
rtifica ng ph as th	l o	IE EENAL E							
w requires that the death certific been signed by the attending p should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		∃Ectopic pregnancy			23d. Date of o	•
ne dea the att	Sicia	in the past 12 months?  1 Yes 2 No	4□Pregnant at tim 9□Unknown		Other (specify)			Month	Day Year
at the	Phy	9 Unknown							
res th	by	Part II. Other significant conditions	contributing to death but n	ot resulting in the u	inderlying cause give	en in Part I.		Δ.	to the cause of death?
w requires to been signed should be	ted	Demonte					1 🗆 Yes	22 No 3 🗆	Probably 4 Unknown
a law	Completed						24a. Was an autopsy	prior t	autopsy findings available o completion of cause of
icien: The lav certificate has rector, page 2	Co						performe 1 ☐ Yes 2		? es 2□ No
iclen sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		24		h (Check only one)		
Phya this	-T	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outpatier	nt 3 DOA	Nursing Ho	ome 5 Residen		pecity)
dlng h. After funel	tion	Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	par) Injury	Work	rat (? Yes 2 □ No	28d. Describe how	injury occurred	
Attending Phyaiclen: The last death.  ector: After this certificate has by the funeral director, page 2	Certification:	3 Suicide 6 Could not b		At home, farm, str		.03 20.00	28f. Location (Stre	et and Number or	Rural Route Number,
after after Dire	erti	4  Homicide	28e. Place of Injury building, etc. (5	Specify)	, and a , a , a , a , a , a , a , a , a , a		City or Town,		ridia ridate rambor,
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying P	nysician: To the best of m	y knowledge, deat	h occurred at the tim	ne, date and place.	and due to the cau	se(s) and manner	as stated.
n 24 l n 24 l se Fu	edical	(Check only 2 Medical Exa	niner: On the basis of exand manner stated	amination and/or in	vestigation, in my op	pinion, death occur	red at the time, date	and place, and d	ue to the cause(s)
To the within To the comp	M	29b. Signature and title of certifier			29c. License	number	290	I. Date signed (Mo	nth, Day, Year)
7/		Dem In. K	In Ms		D23	124	ALC	VEMBE	2 15 7 mar
		30. Name and address of person who	completed cause of death	n (Item 23a) (Type,	Print)	,			17,000
		DENNISHAND	JON AB	29010	WRY-SA	NDYSI	BSINPB	110 CV	VEY MD
	ate	31. Date filed (Month, Day, Year)	32 Registrar's	Signature	alle)				7
Regist	ırar	NOV 1 6 20	105 Kelence	Jos Maria					

		٠.	For State Registrar	State of M		partment of Healti ertificate of Dea	n and Mental Hyg th	giene -9.2.005	39012
Ψ.	Thysisi		1. Decedent's Name (First, Middle,	Last)			2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medio	- 10	Alc McKinne				Novembe	er 6 2005	9:15p <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution,			4b. City, Town, or Locati		4c. County of Death	
	Funeral		Washington Adv 5. Social Security Number 6		pital je (In yrs. last birthda	Takoma Park  y) If Under 1 Year   If Un	der 24 Hrs. 8. Date of Birth	Montgomes 9. Birth	place (State or Foreign
	Funeral Director		579-42-6787	1 ☐ M 2 🕱 F	<b>85</b> Yrs.	Months Days Hou	Min. (Month, Day	( Year) Cou	intry)
-	p ,		Usual Residence of Decedent		I too City To				
	shov	2	10a. State 10b. County		10c. City, Town or				10d. Inside City Limits 1    Yes 2   No
	28a-1	ecto	D.C.  10e. Street and Number		Washing	10f. Zip Code		log. Citizen of What Cou	
	Mith Ba or	ij	1140 North Cap	itol Street	N.W.	2000		USA	
9	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic event, the Medical Examinar must be notified at	/ Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Armed Forces	Ever in U.S. 13	B. Was Decedent of Hispanic If Yes, specify Cuban, Mex 1 ☐ Yes 2 ☐ No Spec	Origin? (Specify Yes or No- ican, Puerto Rican, etc.)	14. Race - Amer Black, White Specify:	, etc.
21215-0036	ural',	d by	3 AWidowed 4 □ Divorced	Year or Dates:					Black
2	n 72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	(Giv	edent's Usual Occupation re kind of work done during t . DO NOT use retired)	nost of working	16b. Kind of Business/li	ndustry
212	iene.	omp	Elementary/Secondary (0-12)	College (1-4or	5+)	omemaker		Own Home	
פ	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, La	est)			other's Name (First, Middle,	Maiden Surname)	
<u>a</u>	should be nd Mental marked c	To E	Arthur Smith				Alberta Guntl	horp	
Maryland	and 2 sho salth and n 27 is my		19a. Informant's Name/Relationship Llewellyn McKin			*	mber or Rural Route Number , <b>Hyattsville</b>		p Code)
altimore,	as 1 a		20a. Method of Disposition		20b. Place of Dis	position (Name of rematory or other place)	Date	20c. Location - City or T	own, State
Ĕ	Page ment ant: If ury o		1 A Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		Fort Lin	coln Cemeter	y 11/12/05	Brentwood,	Maryland
Balt	permit. Pages Depertment of I Important: If its eny injury or o		21. Signature of Funeral Service Li	censee Mul	len	Part Lincoln 3401 Bladens	Funeral Home burg Rd., Bre	ntwood, MD	20722
<b>)</b>	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	omplications that cause only one cause on each I RES	d the death. Do not e ine.		AILURI	_	Approximate Interval Between Onset and Death
	/Medical Examiner		Sequentially list conditions,	b. Asp	a consequence of):	ON PN	EUMOA	IA	
	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):	0 440.		TATE OF	
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	D MEY	ITAL S	TATUS	
8760,	be e sician buria	dicai E		CF	P.CIC				
687	ificate physics the				- 1 - 2 1 - 2				
.O. Box	requires that the death certificent is signed by the attending thould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	B Ectopic pregnancy Dother (specify)		23d. Date of deliv Month	very Day Year
rds, P	w requires that been signed b should be det	by	Part II. Other significant condition	s contributing to death t	but not resulting in the	underlying cause given in P	on C	bacco use contribute to es 2 □ No 3 □ Pro	
Vital Records,	The law ete has b page 2 si	Completed	Congos	luie	hear	Faile	24a. Was a autope perfor	24b. Were aut sy prior to co death? 2 XNo 1 Yes	opsy findings available ompletion of cause of 2 No
Vita V	Physician: this certific ral director.	Be	25. Was case referred to medical examiner?	Hospital:			lace of Death (Check only or	10)	
	d is	2	1 Yes 2 No	Hospital:			Nursing Home 5 Resid	ence 6 Other (Spec	(fy)
0	ding h. After fune	tion	1 XNatural 5 ☐ Pending	28a. Date of Inj. (Month, Da	ay Year) Injun		_	ow injury occurred	
Division of	al or Attending after death. I Director: After d in by the fune	Certification:	2 Accident investigation of Could not determine	t be 28e. Place of In	jury - At home, farm, tc. (Specify)			treet and Number or Rui n, State)	ral Route Number,
	Hospita 24 hours Funeral	dicai	29a. Certifier (Check only one)  Certifying  Certifying  Let Medical E	Physician: To the best xaminer: On the basis of and manner s	of examination and/or	ath occurred at the time, date investigation, in my opinion,	and place, and due to the c death occurred at the time, d	ause(s) and manner as late and place, and due	stated. to the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier	^	A 11	29c. License numb	per 2	29d. Date signed (Month	, Day, Year)
			· Y· Ce	'Our	N. My	1 0 45	-490	11/7/0	
2	(6)		30. Name and address of person w	ho completed cause of	death (Item 23a) (Typ	e, Print)	- 22 0. 72	1111	
			DR. Y. Gur	TA 100	TAVIV	6 ST 1/4	SHINGTEN 1	C. 200	10
	Sta Regist	ate rar,	NOV 1 5 2005	Regist 32. Regist	trar's Signature				

			For State Registrar	State of Maryland	/ Depa	irtment of F tificate of	lealth and M <i>Death</i>		ene 005	39013
agrag.	Physici		1. Decedent's Name (First, Middle, Last) Alberta J					2. Date of Death	1	3. Time of Death 6:30 A. M
	/Medic Examin		4a. Facility Name (If not institution, give Prince George's Hospi				r Location of Death		4c. County of Deat Prince Geo	th
I	Funeral Director		5. Social Security Number 6. Sex		st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, December 1	Year) 9. Birt	thplace (State or Foreign buntry)
	TO .		Usual Residence of Decedent  10a. State 10b. County	10a City	Town or Lo	nation			, 1/20 NOS	10d. Inside City Limits
	Maryla -f shov	tor	D.C. 10b. County	loc. City,	TOWN OF LO	Was	nington			1√√Yes 2 No
	h with the 23a or 28e st be noti	al Director	10e. Street and Number 1343 Downing Street	-, N.E.		10f. Zip Code	20018	10	og. Citizen of What Co U.S.A.	ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "naturel" or items 23a or 28e-f show early injury or other treumatic event, the Medical Examinational Examinational agree.	by Funeral	11. Marital Status  1 ☐ Never Married 2XXMarried  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZXXNo If Yes, Give Year or Dates:	í	Vas Decedent of I Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: U	e, etc.
21215-0036	n 72 hou "nature edical E	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	ent's Usual Occup kind of work done OO NOT use retire	during most of work	ing 1	6b. Kind of Business	/Industry
212	d withi giene. er then	Somp	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+)		rition Sy			NIH	
Maryland	d be file ental Hy ked oth	To Be (	17. Father's Name <i>(First, Middle, Last)</i> <b>Herbert Co</b>	ates			18. Mother's Nam-	e (First, Middle, M Madlin		
lary	2 shoul and Ma Is mari reumati	F	19a. Informant's Name/Relationship (Ty			,		· ·	City or Town, State, 2	
	s 1 and f Health item 27 other t		Mr. John M. Marie (Husba 20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of natory or other pla			0.000, D.C. $2001$	
altimore,	Page Iment o tent: If jury or		1  urial 2  Cremation 3  F '4 Donation 5  Other (Specify)	emoval from State   Linc	oln Mer	morial Cem	etery Novemb		)5 Suitland,	
Ba	Depart Import eny in		21. Signature of Funeral Service Licens	burn		. Name and Addre 39 <b>Hunt</b> Pla	ess of Facility Face, N.E. Wa		eral Home, I D.C. 20019	nc.
			282 Part1. Enter the disease, or compleshock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		er the mode of dyi	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due to (or as a conseque						
	Examiner	_	Sequentially list conditions,	Possible Pulmo		mbolism				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Due to lor as a conseque	ance org.					
68760,	icate be executed physician and s the burial-transit	edical Exa	resulting in death) Last	Due to (or as a conseque	nce of):					
	artificat ing phy e as the		IF FEMALE:			·	1.00			
P.O. Box	Attending Physicien: The law requires that the death certific releath. sctor: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetaf of 4 □ Pregnant at time of dea 9 □ Unknown	leath 3	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	livery Day Year
	quires that n signed bi	by	Part II. Other significant conditions col Renal Failure	ntributing to death but not result	ing in the ur	nderlying cause gh	ven in Part I.	1	acco use contribute to s 2 □ No 3 □ Pr	o the cause of death?
Division of Vital Records,	The law requirate has been sinage 2 should b	Completed						24a. Was an autopsy perform 1 Yes 2	prior to	utopsy findings available completion of cause of
/ital	Physicien: The this certificate har all director, page	BeC	25. Was case referred to medical examiner?					h (Check only one		
of	Physic this c	- To	1 Yes 2X No	lospital: 1 ☐ Inpatient 2 ☐ El 28a. Date of Injury 2	R/Outpatien	3 DOA		me 5 Reside	nce 6 Other (Spe w injury occurred	cify)
on	ath. r: After e funer	atlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	28c. Inju Wo M 1	rk?  Yes 2 □No		,	
Divis	l or Atte after des Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number or Ri , State)	ural Route Number,
	To the Hospital or Attentwithin 24 hours after deatle to the Funeral Director: completely filled in by the	edical		sician: To the best of my knowner: On the basis of examination and manner stated.				red at the time, da	ite and place, and due	to the cause(s)
1	To the	Σ	29b. Signature and title of certifier	CO.DA		29c. Licen	D45490		od. Date signed <i>(Mont</i> bvember 7, 2	
	900		30. Name and address of person who co							
	Sta	at a	Yuth Gupta, M.D. 1 31. Date filed (Month, Day, Year)	06 Irving Street, 32. Registrar's Signatu		uite #415	washington,	D.C. 2001	LO	
	Regist		11014	en It Spe						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 11 per wife 2860 10-6-06 vt. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** egina November 8 2005 7:10 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hyattsville Prince George's St. Thomas More Nursing Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | Mar. | 20, 1 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 1**X** M 2□ F Yrs. 52 Director 577-70-0103 Wash., Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show en "naturel", or items 23a or 28a-f shov Medical Examiner rust be notified at 1 XYes 2 No Director Prince George's Hyattsville Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20772 4922 LaSalle Road United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after ☐ Yes 2**X** No f Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify. Black. þ 3 ☐Widowed ◆ ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Ine Government Employee Government other ulth and Mental Hygie 27 Is marked other r treumetic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert B. May, Sr. Marion Jackson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 le any injury or other trei once. Natalie May - Daughter 7426 - 9th St., N.W. Wash., DC 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Harmony Memorial Park 11/15/2005 5 Other (Specify) Landover, MD 4 🔲 Ronation 21. Signature of Ineral Service Licenspe 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached o 9 Unknown 9 Unknown à Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 21X No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Wursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 📉 No 2 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. nerel Director: A investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a Hospital 1 💢 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) title of certifier 29b. Signature and

Registrar

4922 LaSalle Road, Hyattsville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Yudh Gupta,

Year)

NOV 1 5 2005

November 8, 2005

20772

			1 - State Registrar 11-18-05 Ame		Maryland/De ED PGC cr C				and M		giene	15	39015
**	Physici		Decedent's Name (First, Middle, L Charles Eric	ast)						2. Date of Dea Month	ath Day	Year	3. Time of Death
4	/Medio Examir		4a. Facility Name (If not institution, girl PRINCE GEORGES H	ve street and numbe			Town, or	Location o	f Death	NOVEMB	4c. Cour	2005 nty of Deat CE GE	11:56P. <sup>™</sup> ORGES
	Funeral Director		577-96-7541	Sex 7. A	Age (In yrs. last birtho 34 Yrs	Months	1 Year Days	If Under : Hours	24 Hrs. Min.	8. Date of Birtl (Month, Day 12/94/1	/, Year)	Co	hplace (State or Foreign untry) nington, DC
	after death with the Maryland or items 23s or 28s-f show	tor	Usual Residence of Decedent  10a. State 10b. County  D.C.		10c. City, Town o								10d. Inside City Limits 1 ☐ Yes 2 No
	vith the	Director	10e. Street and Number	C.T	//202	10f. Zip					10g. Citizen o		untry?
	na 23a	Funeral	2842 Robinson Pla	12. Was Deceder	#202		2002		nin? (Sne	cify Yes or No-		S.A.	rican Indian,
920	72 hours after death with the Maryland "natural", or Itema 23a or 28a-1 ahow idical Exacult at must be notified at	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces  1  Yes 2  If Yes, Give Year or Dates	] No	If Yes, spec		Specify:	, Puerto	cify Yes or No- Rican, etc.)	1	lack, White	e, etc.
Maryland 21215-0036	d within 72 ho piene. r than "natur rre Medical.	Completed	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12) 12th		(G	ecedent's Usua live kind of wor fe. DO NOT us ail Sor	rk done d se retired	durina most	of worki	ng	16b. Kind of		•
ind 2	be filed tal Hygi d other event,	Be	17. Father's Name (First, Middle, Las	t)						(First, Middle,	Maiden Suma		
ryla	Men	ဥ	Charles Moody  19a. Informant's Name/Relationship	(Type Print)	19h M	alling Addross	/Stroot o	_		ontgome		- Ctota	Tip Code) 20020
	12 s h ar 7 ts treu		Mary Montgomery -							E #202;			
ore,	Se do		20a. Method of Disposition  № Burial 2 Cremation 3	☐Removal from Stat	20b. Place of Di cemetery,	sposition (Nan crematory or o	ne of ther plac	e)	D	ate	20c. Location	n - City or	Town, State
Baltimore,	글론환경 .		4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Ft. Li	ncoln 22. Name an		s of Facility	1/1	5/05 en Funera	Brent	wood	, Maryland
Ba	Depa Impo Any i		* Kenalan	treen	an	P.O.Box	416;	Suitla	nd, M	an Funera bryland	11 Service 20752	æs	
14	Physician		23a. Part 1 the disease, or cor shock, or heart failure. List ont Immediate Cause (Final disease or condition			enter the mod		g, such as o	cardiac o	r respiratory ari	rest,		Approximate Interval Between Onset and Death
-	/Medical Examiner		resulting in death)	Due to (or a	is a consequence of):	1	-						
	P #	ner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to for a	is a consequence of								
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequence of):							-	
8760,	cate be e	dical		d									
O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			3 ☐ Ectopic pro						Date of deli Month	very Day Year
Ω.	es tha	by	Part II. Other significant conditions	contributing to death	but not resulting in th	e underlying ca	ause give	en in Part I.		23e. Did to			the cause of death?
of Vital Records,		Completed								24a. Was a autops perfor	an 24b sy med? 2 \square	prior to c death?	topsy findings available completion of cause of
Vita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othe	200		Check only or			
		n; To	1 X Yes 2 No 27. Manner of Death	1 ☐ Inpa 28a. Date of In (Month, D	jury 28b. Tim	e of 2	8c. Injury Work	4 🗆 1401		ne 5 Reside		i <del>hor (Spec</del> irred	Hopital-
Division	tendir leath. tor: Af the fur	Certification;	1 □Natural 5 □ Pending 2 ☑ Accident investigate 3 □ Suicide 6 □ Could not	in 11/3/0	05 11:24	М	1 🗆 \	res 2,		Bicyclist			
Divi	를 다 다 드	ertifi	4 Homicide determined	286. Flace of I	njury - At home, farm, etc. (Specify)	street, factory	, office			City or Towi	n, State)		ral Route Number,
	To the Hospitel or At within 24 hours after of the Funerel Directompletely filled in by	edical C	29a. Certifier (Check only one)  1 Certifying P	hysician: To the besiminer: On the basis and manner:	st of my knowledge, do of examination and/o	eath occurred a	at the tim	e, date and pinion, deat	place, a	nd due to the c	ause(s) and n	nanner as	Washington, DC stated. to the cause(s)
	vithir To th	W	29b. Signature and title of certifier	****		29c	. License	number		2	9d. Date sign	ed (Month	, Day, Year)
	(1)		30. Name and address of person who	completed cause of	death (Item 23a) (Tim		).C.1	4.E.		NO	OVEMBER	14,	2005
	- De		ANA RUBIO	MD completed cause of	qeatii (iteili 23a) (Ty		PENN	STREE	ET BA	ALTIMORI	E MARYI	AND	21201
	Sta Registi		NOV 1 5 2005	32. Regis	trar's Signature								

			For		State of Ma	ryland / Depa	artment of H	lealth and M	ental Hyg	jiene	
			For State Registrar			Ce	rtificate of	Death	F	10g. No. 2 0 0 5	39016
	Physicia	an	1. Decedent's Name Ruth	e (First, Middle, Las Eugenia	Monasters	ski			2. Date of Dea Month NOV •	Day Year 9 2005	3. Time of Death  10:30 P M
	/Medic Examin	_	4a. Fecility Name (f	f not institution, give	e street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
				Magnolia			Lanh			Prince C	
	Funeral Director		5. Social Security N 229-01-5	604	ex 7. Age	(In yrs. last birthday) 84 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day May 11	, Year) 9. Bir , 1921 Alt	chplece (State or Foreign country) a Vista, VA
	and and	}	Usual Residence of 10a. State	10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary -1 ehc	ğ	MD	Montgome	erv	Brookevi.	lle				1 Yes 2 □ No
	h the	Director	10e. Street and Nur		4		10f. Zip Code			10g. Citizen of What Co	ountry?
	th wil	aic	2505 Sar	oling Rid	ge Lane		2083			USA	
	lems	Funeral	11. Marital Status		12. Was Decedent E Armed Forces?		Was Decedent of H If Yes, specify Cubi	Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at an Once.	by F	1 ☐ Never Marri 3 ☑ Widowed	ied 2 ☐ Married 4 ☐ Divorced	1 ☐ Yes 2 🕅 N Il Yes, Give Year or Dates:	10	1 ☐ Yes 2 No	Specify:		Specify: Wh	ite
21215-0036	2 hou	ted		15. Decedent's E	ducation	16a. Dece	edent's Usual Occup	oation during most of worki	na	16b. Kind of Business	
215	thin 7 e.	Completed	Elementary/Seco	ondary (0-12)	College (1-4or 5	+)	DO NOT use retire	d)	,,9		
	ygien her th	S	12	(First Adiable Land	,	5	Secretary	18. Mother's Name	(First Middle	U.S. GOV	t.
and	ntal H	Be	17. Father's Name						Church		
Maryland	should ind Mening marke	ို		r Reynold ame/Relationship (		19b. Mail	ing Address (Street			or, City or Town, State,	Zip Code)
M	and 2 s allth an 27 is r trau				an / daugh	ter 2505	Sapling	Ridge Lan	e Broo	keville, M	D. 20833
re,	s 1 ar		20a. Method of Dis	•	3= 11 011	20b. Place of Disp	osition (Name of ematory or other pla	ce)	ate	20c. Location - City or	Town, State
Ē	Page nent c ant: If			∑Cremation 3 ⊆ 5 ☐ Other (Special	Removal from State (y)					Alexandria	, VA.
Baltimore,	permit. Departnimports		21. Signature of Fu	neral Service Lice	(5) 0/			ess of Facility Bea			
	205 2 9	7. 7		Suan	Youell plications that caused		512 NW Cr		Bowie		Approximate
		8	shock, or hea	art failure. List only	one cause on each lir	10.					Interval Between Onset and Death
	Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a. Cha	a consequence of):	Lymph	caphe	Leui	Com c	
	Examiner					a 001100 quoi 100 01).					
1.8		ner	Sequentially list co if any, leading to in	onditions, nmediate	b. Due to (or as	a consequence of):					
	acuted ind transi	Examiner	Cause (Disease or that initiated event resulting in death)	r injury s	c						
,09	be executed sician and burial-transit	al Ex	resulting in death)	Last	Due to (or as	a consequence of):					
687	ath certificate I attending physi for use as the b				d						
Box 6	death certificate e attending phys d for use as the	Physician/Medic	IF FEMALE: 23b. Was deceder	nt pregnant	23c. If yes, outcome					23d. Date of de	livery
B.	death e atter	iciai	in the past 12	2 months?	4☐Pregnant at		□Ectopic pregnanc □ Other (specify) _	:у		Month	Day Year
P.0	t the by th	hys	9 Unknown	1	9□ Unknown						
Ś	es tha igned be de	by F	Part II. Other signi	ificant conditions	contributing to death b	ut not resulting in the	underlying cause gi	ven in Part I.		obacco use contribute t res 2 <sup>®</sup> No 3 □ P	robably 4 Unknown
Record	v requires been signi should be	Completed			<u>-</u>				-		/ -
3ec	law as b	mple		CAD					24a. Was autop perfo	rmed? prior to death?	utopsy findings available completion of cause of
a	ician: The certificate ha rector, page		OF Management	grad to modical	Т			26. Place of Deat	1 ☐ Yes	2 No 1 Ye	s 2 No
Vital	certi	Be	25. Was case refe examiner?		Hospital:	ent 2 ER/Outpatie	ent 3 DOA Ot	hor /		dence 6 □Other (Sp	ecify)
of	00 U =	0	1 Yes 2		28a. Date of Inju	ry 28b. Time		The state of the s		now injury occurred	
	Phys this ral di	n: To	1 Yes 2	ith	(Month, Da	v Year) Injury	VVC				
	ding Phys h. After this funeral dia	H-	27. Manner of Dea 1 ★Natural 2 Accident	th 5 ☐ Pending investigate	(Month, Da	y Ye <i>ar)</i> Injury		Yes 2□No			
	or Attending Physical death. Inector: After this is by the funeral did	H-	27. Manner of Dea	th 5 Pending	(Month, Da	ury - At home, larm, s	M 1	Yes 2□No	281. Location (S City or Tox	Street and Number or F vn, State)	lural Route Number,
<b>Division</b>	or Attending Physical death. Inector: After this is by the funeral did	Certification: T	27. Manner of Dea  1 Natural  2 Accident  3 Suicide  4 Homicide	5 Pending investigated 6 Could not I determined	(Month, Da	ury - At home, farm, s c. (Specify) of my knowledge, dea	M 1	Yes 2 No	City or Tou	vn, State) cause(s) and manner a	s stated.
	or Attending Physical death. Inector: After this is by the funeral did	Certification: T	27. Manner of Dea 1 ★Natural 2 ☐ Accident 3 ☐ Suicide	5 Pending investigated 6 Could not I determined	(Month, Da	ury - At home, farm, s c. (Specify) of my knowledge, dea f examination and/or i	M 1	Yes 2 No	City or Tou		s stated.
	or Attending Physical death. Inector: After this is by the funeral did	H-	27. Manner of Dea  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only)	5 Pending investigated 6 Could not I determined	(Month, Da 28e. Place of Inj building, et hysician: To the best miner: On the basis o	ury - At home, farm, s c. (Specify) of my knowledge, dea f examination and/or i	M 1 citreet, factory, office ath occurred at the toursestigation, in my 29c. Licen	Yes 2 No	City or Tow and due to the red at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mor	is stated. e to the cause(s)  th, Day, Year)
	Hospital or Attanding Phys 4 hours after death. Funaral Director: After this iely filled in by the funeral di	Certification: T	27. Manner of Dea  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)	th  5  Pending investigation 6  Could not I determined	(Month, Da 28e. Place of Inj building, et hysician: To the best miner: On the basis o	ury - At home, farm, s c. (Specify) of my knowledge, dea f examination and/or i	M 1 citreet, factory, office ath occurred at the toursestigation, in my 29c. Licen	Yes 2 No	City or Tow and due to the red at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mor	is stated. e to the cause(s)  th, Day, Year)
	or Attending Physical death. Inector: After this is by the funeral did	Certification: T	27. Manner of Dea  1 Natural  2 Accident  3 Suicide  4 Homicide  29a. Certifier (Check only one)	th  5  Pending investigation 6  Could not lidetermined  1 Secretifying P 2  Hedical Exa	(Month, Da 28e. Place of Inj building, et hysician: To the best miner: On the basis o	of my knowledge, deaf examination and/or i	M 1 citreet, factory, office ath occurred at the toursestigation, in my 29c. Licen	Yes 2 No	City or Tow and due to the red at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mor	is stated. e to the cause(s)  th, Day, Year)
	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification: T	27. Manner of Dea  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b Signatura  30. Name an 34	th  5  Pending investigation 6  Could not lidetermined  1 Secretifying P 2  Hedical Exa	Month, Da  28e. Place of Ini building, et  hysician: To the best miner: On the basis o and memor st  completed cause of c	of my knowledge, deaf examination and/or i	M 1 citreet, factory, office ath occurred at the toursestigation, in my 29c. Licen	Yes 2 No	City or Tow and due to the red at the time,	cause(s) and manner a date and place, and du 29d. Date signed (Mor	is stated. e to the cause(s)

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar HARGDOITS

Date filed (Month, Day, Year)

. Konzu

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 7,8 per fh 9853 3-20-06 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. UU5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician NOVEMBER 25 2005 ALBERTA MACKIE 12:40 L. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Wing-Heron Point Kent Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1913 | Months | Days | Hours | Min. | Dec 2 | 1911 | 1913 | Months | Dec 2 | 1911 | 1913 | Months | Dec 2 | 1911 | 1913 | Months | Dec 2 | 1911 | 1913 | Months | Dec 2 | 1911 | 1913 | Months | Dec 2 | 1911 | 1913 | Months | Dec 2 | 1911 | 1913 | Months | Dec 2 | 1911 | Months | Dec 2 | 1913 | Months | Dec 2 7. Age (In yrs. last birthday) 91 Yrs. 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Maryland 212-38-4301 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Importent: If item 27 Is marked other then "neturel", or Items 23a or 28e-f show any injury or other treumatic event, Ire Madical Examilier is used by neithflied at once. MD Kent Chestertown 1⊠Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Heron Point 21620 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify: þ 3. Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Cecil County Board Elementary/Secondary (0-12) College (1-4or 5+) Elementary school teacher of Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Littleton Edna Webb 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Widener 1767 Meadow Hill Dr. Annapolis, MD. 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rose Bank Cemetery 11/30/05 Calvert, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Full ral Service Galena Funeral Home of Stephen M00510 118 West Cross St. Galena, MD. L. Schaech 21635 23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause Final disease or condition resulting in death) CONGESTIVE HEART **Physician** FAILURE months /Medical Due to (or as a consequence of) Examiner MONARY ANTERY DISGASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): Box 68760, attending physician that the death certificate be Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ DEMENTUA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No or Attending Physicien: after death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funerel ( Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0041587 2005

Registrar

State

122 Speer Rd. Chestertown, MD. 21620

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 $M \cdot D$ .

32. Agistrar's Signature

Helen A. Noble,

DEC 0 2 2005

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene 39020 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Year Month Physician November 18 5:45 a<sup>™</sup> 2005 Hazel Gertrude Owens /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 48058 Turkey Neck Road St. Mary's Lexington Park If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Year Hours 8-6-1924 1 □ M 2 🖾 F Maryland 219-16-1008 81 Director Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or iteme 23a or 28a-1 show other traumatic event, he Medical Examinar number requirible at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 TYes 2 No Funeral Director St. Mary's Lexington Park 10g. Citizen of What Country? 10e. Street and Number 20653 United States 48058 Turkey Neck Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify Be Completed by White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Melvin Pilkerton, Sr. Mary Blanche Pilkerton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Agnes Biggs/Daughter 48095 Turkey Neck Road, Lexington Park, MD 20653 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of H ant: If ite 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury of once. 11-22-2005 Lexington Park, MD Immaculate Heart 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service bicensee 22955 Hollywood Road, Leonardtown, MD 20650 Mon 11100052 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ATHEROCCIGRETIC CARINOVASCULAR Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner TARETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 DEctopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. 1 Yes 2 No 3 Probebly 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director 26. Place of Death | Check only one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 10 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA ۵ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? After t Certification; 1 Delatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ASSOCIATES ATBINDER GILL MAM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 2 2 2005 Registrar

Physician/Medical Š

ed by the a detached t s been signed by is should be detact Completed certificate Be this funeral Certification: After death. al or Attend after death Director: filled in by the

9 Unknown 9 Unknown

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performe

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No

1 Yes 2 No 3 Probably 4 Unknown

Yes 2 🗆 No 26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 MOther (Specify) At SCENE

1 X Yes 2 No 27. Manner of Death 1 Naturaf 2 Accident

3 □,Suicide 4 ☑ Homicide

29a. Certifier

5 Pending investigation 6 Could not be determined

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 11-10-05 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury 20:42 PM

STREE

28c. Injury at Work? 1 Yes 2 No

Other:

28d. Describe how injury occurred 20 cecise C

28f. Location (Street and Number of Rural Route Number of City or Town, State) 1904 Allen dille of andoner, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifig

25. Was case referred to medical

29c. License number OCME

29d. Date signed (Month, Day, Year) November 11, 2005

Baltimore, Maryland 21201 de th (Item 23a) (Type, Print) 111 Penn Street

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

NOV 1 5 2005

To the Hospitel or within 24 hours af

			For State Registrar	State of	of Marylar		artmen rtificate			nd Me	ental Hygi			
		11/12	Registrar  1. Decedent's Name (First, Midd.	le last)		00,	inican	CUIL	Jean		2. Date of Death	g. No.)	<del>105</del> -	3 Time of Death
*	Physici	an			т.						November	Day	Year	1:09 A. M
1	/Medic	-	Jam 4a. Facility Name (If not institutio	es G. Payne	_		4b City	Town or	Location of I		Itovailler		nty of Death	1:09 A.
W. F.	Examir	er	Southern Marylan		,,,,,		40. O.ly,		Lintan	Dogin			ce Geor	mala
		-	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under		If Under 24	Hrs.	8. Date of Birth (Month, Day,			place (State or Foreign
	Funeral Director		577-98-0594	1 <b>X</b> XM 2□ F	30	Yrs.	Months	Days	Hours	Min.	July 16,	<sup>Year)</sup> 1975	Cou	netan, D.C.
			Usual Residence of Decedent								oury ros		T T T	15041, 15.01
	ylan		10a. State 10b. County		10c. Ci	ty, Town or Lo								10d. Inside City Limits
	a Ma	cto	D.C.			Washi	ngtan							1, Otro
	172 hours after death with the Maryland "naturel", or frems 23a or 28a-f ehow edical Examinations to modified at	Director	10e. Street and Number 5097 Just Str	œt, N.E.			10f. Zip	Code	200	19	10		of What Cou U.S.A.	ntry?
	ns 23	Funeral	11, Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Deced	dent of His	spanic Origin	n? (Spec	ofy Yes or No-	14. R	ace - Ameri	can Indian,
<b>'</b> 0	ther o	ᇤ	1 Never Married 2 Mar	ned Armed F	2 <b>XX</b> No		If Yes, spec	cify Cubar	n, Mexican, I	Puerto R	lican, etc.)	1	lack, White,	
036	er's a	by	3 Widowed 4 Divorced	If YAS (3	ive		1 ☐ Yes	2 X No	Specify:			Spec	oity: Bla	ick
Ö	2 ho	Completed		nt's Education est grade completed	1	16a. Dece	dent's Usua	al Occupa	tion uring most o	é unrein	1	6b. Kind of	Business/In	dustry
215	within 7 ene. than "r	pie	Elementary/Secondary (0-12)	T	/ (1-4or 5+)	life.	DO NOT us	se retired)	uring most o	N WOIKIN	9			
2	e filed within al Hygiene. I other than vent, it a we	Son	12th grade			J	hemplo	yed				N	/A	
p	be filed within 72 hc ital Hygiene. id other than "natur event, it is Medical	Be (	17. Father's Name (First, Middle,	Last)					18. Mother's		(First, Middle, M		ame)	
<u> a</u>		၉	James G.	Payne, Sr.						M	rie Botts			
7	12 sho		19a. Informant's Name/Relation: Mr. Ant Juan R. Pay	ship <i>(Type, Print)</i> ne (Brother	•)		-				Route Number, ngton, D.	-	m, State, Zij 019	Code)
	1 an Heall em 2 ther		20a. Method of Disposition	17.0	20b.	Place of Dispo			•	Da			n - City or T	own, State
Baltimore,	0 0		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		State	dar Hill			1	<del>amba</del> r	14, 2005	Shif	land M	kailand
Ħ			21. Signature of Funeral Service		- 0						lins Funs			
B	permit. Departr Importe any infe		ant C	· hadee.	a /						shington,		20019	•
	- 10 <sup>1</sup>		23a. Part1. Enter the disease, o	r complications that	caused the dea									Approximate
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	~	lyocar	dial	Inf	arcti	on				Interval Between Onset and Death HOURS
黄	/Medical Examiner			Due to	Or as a consecutive	quence of): DEPE	ENDE.	NT	DIA	BET	TES			YEARS
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	U	(or as a consec									
	cate be executed physicien and the burial-transit	Examin	Cause (Disease or injury that initiated events	) c										
Ó,	en al	Ë	resulting in death) Last	Due to	(or as a consec	quence of):								
8760,	cate be physici the bu	dical		d										
		Med	IF FEMALE:										1	
Вох	eath certifi attending J I for use as	Physician/Me	23b. Was decedent pregnant		utcome of pregn birth 2 Teta		⊒Ectopic pr	regnancy					Date of deliv	,
Ξ.	deal	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Other (sp						Month	Day Year
P.0	at the de by the a stached	h	9 Unknown											
ds, l	Physicion: The law requires that the death certificate thas been signed by the attending rail director, page 2 should be detached for use as	þ	Part II. Other significant condit.  HYPERTEN							-		acco use co acco use co		he cause of death?
Vital Records,	w require s been signature	Completed	ON DIAYLS	is Pt							24a. Was an	241	b. Were auto	opsy findings available
l Re	The lav	)om	TRACHERO	TOMY							autopsy perform		death?	mpletion of cause of
ita	iicien: Th certificate rector, pag	Be (	25. Was case referred to medica examiner?	al					26. Place o	f Death	(Check only one	)		201
of V	nysic lidirə	2	1 ☐ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	nt 3 DC	Othe	4 🗆 Nurs	ing Hom	e 5 🗆 Resider	nce 6 🗆 C	Other (Specia	(y)
0	ding Ph h. After thi funeral		27. Manner of Death  1. Natural 5 ☐ Pendi		of Injury nth, Day Year)	28b. Time o	f 2	28c. Injury Work	at ?	28	8d. Describe hor	v injury occ	urred	
Sio	endi sath. or: A he fu	ati	2 Accident invest	igation			М	1 🗆 Y	fes 2 □ No	)				
Division	or Att	Certification;	3 Suicide 6 Could 4 Homicide deter	nined 289. Plac	e of Injury - At h ding, etc. (Speci		reet, factory	y, office		28	8f. Location (Str. City or Town,		mber or Rur	al Route Number,
Z	spital ours ( peral		29a. Certifier Certifyi	ng Physician: To th	a bast of my kn	owledge dest	h occurred	at the tim	e date and	place 20	nd due to the ca	ise(s) and	manner se s	tated
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edicai		Examiner: On the										
	To the	Me	29b. Signature and title of certific	er.	•			c. License			29	_	ned (Month,	
	12/1		P. Dr	ndewal			7	000	61614	4		11	14/0	5
-	(0/DE		30. Name and address of person	who completed cau	use of death (Ite	m 23a) (Type,	Print)	RAVIN	DER	511	DHWAN	J l		
	ري پ		9131 PISCATO	UAY RUA	D , CL	INTON	1,1	1 D	20	73	5			
	Sta Regist	ate rar	NUV 1 5 2005	32.	Registrar's Sign	ature								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#1, perDR, G850, 12/2/05 TT

State of Manyand 1 Legible and Montal Hydrians.

			1 - For State Registrar	State of Ma		artment of F rtificate of		l Mental Hy				
	0		Decedent's Name (First, Middle, La	st)		D		2. Date of De		05	3. Time or	f Death
	Physic /Medi		AUSTIA Austin	Stanley R	and	KANI	>	NovemB:	Day 14	2005	1:34	A M
	Exami		4a. Facility Name (If not institution, giv			4b. City, Town, or		ath		unty of Death	-	
			THE JOHNS HOPH				ORE CIT					
п	Funeral Director		5. Social Security Number 6. S 308-32-2653	M 2□F	(In yrs. last birthday,	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Da	ı <i>y, Year)</i>		place (State of	
			Usual Residence of Decedent		73 Tis.			Sept 2	9, 193	32 New	York	
	ehow		10a. State 10b. County		10c. City, Town or L		-		-	1	0d. Inside C	ity Limits
	tha Ma 28a-f e	cto	Virginia None		Alexandri	La					1 <b>XX</b> Yes	2 🗆 No
	든 호텔	Director	10e. Street and Number			10f. Zip Code			10g. Citizen	of What Cour	ntry?	
	도 53 로 23		2504 Dewitt Ave.			22301			USA			
(0	permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itams 23 any injury or other traumatic event, the Medical Examinations once.	Funerai	11. Marital Status  1 Never Married 2XXMarried	12. Was Decedent E Armed Forces? 1X1Yes 2 1 N		Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? n, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	14.	Race - Americ Black, White,		
215-0036	al', o	þ	3 Widowed 4 Divorced	1 X Yes 2 □ No If Yes, Give 1 Year or Dates.	957 <sup>955</sup>	1 ☐ Yes 2🌠 No	Specify:		Sp	ecify: Whi	te	
5-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occupa	ation		16b. Kind	of Business/Inc	dustry	
2	ithin Ban	nple	Elementary/Secondary (0-12)	College (1-4or 5-	-) (Give	kind of work done of DO NOT use retired	iuring most of w )	onxing				
121	lled w lygier har tl nt, In	S	17 Fethoria Nama /First Middle 1 and	5+	Resear	ch Biolog				sonian	Insti	ltuti
and	d ba finital hed of	Be	17. Father's Name (First, Middle, Last) Austin L Rand					ame (First, Middle,	Maiden Sur	name)		
Maryland	should ad Me mark matic	2	19a. Informant's Name/Relationship (	Type Print)	10h Maili	on Address (Ctrost		Medden				
<b>≥</b>	od 2 s lith ar 27 is r trau		Patricia J Rand -			ng Address <i>(Str</i> eet a Dewitt Av					Code)	
ē,	s 1 au f Hea item otha		20a. Method of Disposition		20b. Place of Dispo	sition (Name of	T	Date		on - City or To	wn, State	
Baltimore,	Page lent o nt: If ry or		1 ☐ Barial 2 X Cremation 3 ☐ '4 ☐ Donation ☐ Other (Specif		Everly Cr	matory or other place ematory		17/05		dria,		
alti	permit. Departm Importa any inju		21. Signature of Funeral Service Licer		1 1 "	2. Name and Addres						<u> </u>
0	e d m e		JUN HM	Sina		500 W Bra						
	Physician /Medical Examiner	Je	23a Part1. Enter the disease, or orm, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. SEPSIS  Due to (or as a  PNSUM	consequence of):	er the mode of dying	g, such as cardi	ac or respiratory ar	rest,	2	Approximate Interval Betwoen Conset and E	ween
68760,	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· INVASIL	consequence of):	r cancer					o Mon	77-65
P.O. Box	that the death certificated by the attending posterior is detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				Date of delive Month	*	'ear
Vital Records, F	w requires tha baan signed should ba dei	Completed by P	Part II. Other significant conditions of AORTIC STEWOSU	ontributing to death but	not resulting in the ur		n in Part I.	23e. Did to		ontribute to the	e cause of de	
၁၁	a law requ has baan je 2 shouli	plet	DIABETES MELLIT	US				24a. Was		b. Were autop	sy findings a	available
E.	Tha ate ha	mo	PROSTATE CANCER					autop perfor	med? 2 No	death?	npletion of ca 2 <b>℃</b> No	use of
/ita	sician: Thi certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of De	eath (Check only or		1 1 1 1 1 1 1	200 140	
of \	Physician: this certificatal director, p	ို	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Other	4 Nursing	Home 5 Resid	ence 6 🗆 (	Other (Specify,	)	
	ng fter	ilon:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work		28d. Describe h	ow injury occ	urred		
Division	or Attending after death. Director: After in by the fune	ficat	2 Accident investigation 3 Sulcide 6 Could not be	28e. Place of Injun	/ - At home, farm, stre		es 2 No	29f Location (C	troot a and Alice			
Div	pital or Attendii urs after death. aral Director: A illed in by the fu	i Certification:	4 Homicide determined	building, etc.	(Specify)			28f. Location (S City or Tow	n, State)			
	To the Hospital of within 24 hours af To the Funeral D completely filled in	fedicai		vsicien: To the best of iner: On the basis of e and manner state	my knowledge, death xamination and/or inv id.			e, and due to the curred at the time, d	ause(s) and late and plac	manner as sta e, and due to	ted. the cause(s)	
	To To Con	Σ	29b. Signature and title of certifier			29c. License				ned (Month, D		
	10		100412		I.D.	RES-	000	/	VOUEMB	ER 14,	2005	
-	(10)		30. Name and address of person who o	ompleted cause of dea	th (Item 23a) (Type, I	Print)	D					
	Sta	te.	MATHEW PIPELIA 31. Date filed (Month, Day, Year)	□ 600 /	Signatura	E STREET	SALT.	IMORE, M.	ARYLA	up 212	82	
*	Registr		NOV 1 6 2005	E. A	k /							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year 500.5M 2005 /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death eninsula Legional Medical Cente alis Year 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) XXM 2 F Days Months Hours Min 233-70-1047 Director 62 1, 1943 Logan, W. VA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits rel', or items 23a or 28a-f ehor Exeminer west by notified at Director 1 X Yes 2 □ No DE Kent Harrington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 956 Fernwood Drive 19952 by Funeral Pages 1 and 2 should be filed within 72 hours after deeth United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 ☐ Widowed 4 X Divorced "naturel", White tal Hygiene. d other then "nature event, ir e Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Self-Employed Contractor Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be marked 2 George Robison Emma (Kennedy) Robison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Sue Wardwell (Companion) 956 Fernwood Drive, Harrington, DE Item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of important: If eny injury or once. Summit Cremation Serv 11/18/2005 Wyoming, Delaware 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Melvin Funeral Home, 15522 S. 21. Signature of Juneral Service Licenses none-DuPont Hwy., Harrington, DE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** (GZEBELLAR EMUZIZHAGE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to in imediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Cther (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? INTRAVONTRICULAR HEMURIZI+AGE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYDROCEPHALL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy perform of Vital 1 Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation death. 2 Accident 1 Yes 2 No filled in by the 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or To the Hospital of within 24 hours of To the Funeral D completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 13. Nov 2005 (2) person who completed cause of death (Item 23a) (Type, Print) PICILE, 100 E. CARLOII M.O. 31. Date filed (Month, Day, Year) 32. Regisar's Signature State Registrar NOV 1 6 2005

			1 - For State Registrar	State of	Maryland / [		artmen rtificate			and M		giene Reg. No	000	390	26	
П	Physici	an	Decedent's Name (First, Middle,	Last)							2. Date of De	ath Da	y Year	3. Time o	f Death	
	/Medi		Richard Allen R				1				Novemb	er 1	7, 2005		P M	
4	Examir	ier	4a. Facility Name (If not institution,						Location o	of Death		40	. County of Deat	h		
			Union Hospital  5. Social Security Number 6		County  Age (In yrs. last bin	thday)	E1kt If Under		If Under 2	24 Hrs	8. Date of Bir	th.	Cecil	halass (Ct. t.		
	Funeral Director		212-62-6396	1 <b>X</b> □M 2□F		Yrs.		Days	Hours	Min.	(Month, Da	y, Year)	Co	hplace (State untry)		
	ס		Usual Residence of Decedent								Jall. 1	2,19	53 West	virgi	nia	
	show	-	10a. State 10b. County		10c. City, Town									10d. Inside C	*	
	88a-f	ecto	Maryland Cecil		Elk	con									2 🕅 No	
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene. Item 27 is marked other then "natural", or itams 23a or 28a-f show other treumatic event, If a Modical Exeminal Charles by notified at	Funeral Director	10e. Street and Number 194 Hilltop Road			10f. Zip Code 21921							tizen of Whal Co ced Stat	-		
	tams	nue	11. Marital Status	12. Was Decede Armed Force	es?	13.	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I				cify Yes or No Rican, etc.)	-	14. Race - Ame Black, White			
36	rs afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 If Yes, Give Year or Date		1 ☐ Yes 2	No No	Specify:		Specify.Wh			ite			
21215-0036	2 hou	ed	15. Decedent's	Education		Deced	dent's Usua	I Occupa	tion			16b. K	and of Business/			
215	hin 72	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4		(Give	kind of wor DO NOT us	k done d	urina most	t of workin	g					
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yla	should be filed withind Mental Hyglene. I marked other then umatic event, II.e.M.	မ	Harry Vinson Rin								May Si					
Maryland	d 2 sho h and 7 is m		19a. Informant's Name/Relationship Richard Rinehart										or Town, State, Z	ip Code)		
	1 and 1 Health Iem 27		20a. Method of Disposition	, 51./5011					T		kton,M			Town State		
altimore,	Pages nent of h ant: If ite		1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		L .			her place	) No	vemb	er 22,	yom	ing, West Virginia			
i i	F # #		21. Signature of Foneral Service Li		Bud Cer			d Addres	s of Facility	ZU.	uch Fu	nara	1 Home			
ä	Departimon important in any ir	21. Signature of Faneral Service Libert 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, MD											1901			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approxim													
	Priysician:	i O	Immediate Cause (Final disease or condition resulting in dealth)  a. ACTE Myo CMD DINE IN FRANCTION										Onset and	Death		
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	- Adminici	٦	Sequentially list conditions,	b. Dup to for	b. Due to (or as a configuration of):											
V	nsit	nine	Sequentially list conditions, in any leading to important cause. Enter Underlying Cause (Disease or injury	as a contractionation	market try											
,	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence of	of):		-								
8760,	ate be hysicia the bur			d												
9	ntifica ng ph as th	Jedi	ICCENALE.													
Вох	eath certific attending p for use as I	an/h	IF FEMALE:  23b. Was decedent pregnant  1□Live birth 2□Fetal death 3□Ectopic pregnancy							23d. Date of deli						
	at the dea by the at tached fo	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∐Pregnan 9∐Unknow	t at time of death n	5 🗀	Other (spe	cify)					Month	Day *	Year	
P.0	res that the igned by be detact			s contributing to deat	h but not resulting in	t resulting in the underlying cause given in Part I. 23e.						phacco u	use contribute to	the cause of r	leath?	
of Vital Records,	The law requires that the death centificate be executed the has been signed by the attending physician and hage 2 should be detached for use as the burial-transit	ted by	Essen7		17 RM	Z	en	110	27			'es 2[			Inknown	
ec	e law i has be	Completed									24a. Was autop	sy	24b. Were aut	opsy findings ompletion of c	available ause of	
al F		Co										med? 2 No	death?	2□ No		
Vita	Physicien: r this certifica ral director, i	Be	25. Was case referred to medical examiner?	Hospital:	A.r.	-	-	Other			Check onl or					
of	Phys r this ral di	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inp				4	4 LINUI	-	e 5 🗆 Resid		6 Other (Spec	ify)		
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Division	iel or Attendii s after death. el Director: A ed in by the fu	ifica	3 Suicide 6 Could not	ad 286. Place of	Injury - At home, far	m, sire	eet, factory,	office	- 227	28	Bf. Location (S	treet and	d Number or Rui	al Route Num	ber,	
	s afte	Certification:	4 Difficing	bullding,	etc. (Specify)						City or Tow	n, State,	)			
	To the Hospitei or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	edical (	29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physicien: To the be eminer: On the basi and manner	s of examination and	death	occurred a restigation,	it the time	e, date and nion, death	d place, ar h occurred	nd due to the o	ause(s) date and	and manner as: place, and due	stated. to the cause(s	)	
	To the within To the Comp	Me	29b. Signature and title of certifier	7-				License			- 2	29d. Date	e signed (Month,	Day, Year)		
)			40/1/	Cm			0	01	85	81	ne !	11	1/201	/2cc	5,	
	4		30. Name and address of person when 303 So H	o completed cause of	of El	Туре, і	Print)	1 1	40	2	1921	,	1/201			
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	Registr	ar	NOV 2 1 200	Buch	IN A	-										

Registrar

State

12-140G

2 9 2005

31. Date filed (Month, Day, Year)

AN

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 8:00 P M Radcliffe November 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Genesis Eldercare at Woodside Montgomery 8. Date of Birth (Month, Day, Y Aug. 28, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) 1917 **Funeral** 11€ M 2 □ F 88 England 220-34-7829 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County r then "natural", or Itema 23s or 28s-f ehow the Madical Examinat must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20910 Funeral 1710 Highland Drive 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x ☐ No Specify Specify: White ۵ 3 Widowed 4 Drvorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physicist Systems Analysis permit. Peges 1 end 2 should be filed v Department of Health and Mental Hygie Important: If Itam 27 Is marked other? or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Winifred Hilley Horace George Radcliffe ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jean R. Radcliffe/ Wife 1710 Highland Drive, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State November 15 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory \* 4 ☐ Donation 5 ☐ Other (Specify) 2005 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc 21. Signature of Funeral Service Licensee 500 University Blvd, W, Silver Spring, MD 20901 23a. Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Pancreatic Cancer Years /Medical resulting in death) Due to (or as a consequence of) Examiner Metastatic Cancer Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the a should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Ž∏ No 1 ☐ Yes 2 ☐ No this certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient Other: 4x Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 1 Tes 2 🔀 No 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Director: After 5 Pending investigation 1 XNatural 1 Yes 2 No 2 Accident pletely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funeral E 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Mile of certifier 29d. Date signed (Month, Dey, Year) 29c. License number D32332 November 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh K. Gupta, M.D. 9801 Georgia Avenue, #220, Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 16 2005 Registrar

		1.	For State Registrar	tate of Maryland		artment of Health tificate of Deat			ene 3. No. 0 0 5	39030	
		1.	. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death	
Physi			Ethel M. Rou	ndfield				November	7 2005		
/Med Exam		48	a. Facility Name (If not institution, give stre			4b. City, Town, or Location	on of Death		4c. County of De		
			1676 Langley Dr	., #303		Hagers		o Data of Birth		hington	
Funera	al	5.	Social Security Number 6. Sex	7. Age (In yrs. la	st birthday) Yrs.	If Under 1 Year If Und Months Days Hour	rs Min.	8. Date of Birth (Month, Day,	Year)	irthplace (State or Foreign Country) ash., DC	
Directo	or		577-24-5569	84				Nov. 22,	1920 W	asii., DC	
and		-	Usual Residence of Decedent  Oa. State  10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
Manyl f sho	Ď	,	Maryland Washingt	on		Hagers	stown			1X Yes 2 No	
the 1	le C	1	Maryland Washingt Oe. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?	
death with the Maryland ims 23a or 28a-f show irmust be notified at	Q je		1676 Langley	Dr., #303			1740		States		
I Z I 3-UU30 within 72 hours after death with the Marylan ene. Ithan "natural", or Itams 23a or 28a-f show the Medical Exert. her must be invitited at	Funeral Director	1	1. Marital Status	Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Spe tican, Puerto F	cify Yes or No- Rican, etc.)	14. Race · Ar Black, W	nerican Indian, hite, etc.	
after or Ita	hv Fu		1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2X No Spec	cify:		Specify: B	lack	
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be filed wit tal Hygiene d other the	0	, 1	17. Father's Name (First, Middle, Last)			18. M		`	faiden Sumame)		
VIANCE puld be file Mental Hy arked oth	2		Thomas Roots		Eunice J	_	71: 0: 4:1				
Marylan d 2 should be th and Mental 27 Is marked or traumatic ev	1		19a. Informant's Name/Relationship (Type			ng Address (Street and Nu					
2 5 # 2 E		1	Harold R. Kirby /			Brookridge I			20c. Location - City		
altimore, rmit. Pages 1 a spartment of Hez portant: If item ty Injury or othe		ľ	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rea	noval from State	emetery, cre	matory or other place)	1				
Pages Iment of tant: If it			* 4 □ Donation 5 □ Other (Specify)			ret Cemetery 2. Name and Address of F			Wash., uneral Ho		
Baltimory permit. Pages Department of H Important: If ite	Suce		21. Signature of Funeral Service Licensee	+ 11		4001 Benni					
	ŭ	+	23a. Part . Enter the disease, or complication	ations the caused the deat	n. Do not er					Approximate Interval Between	
R TO S	8		shoo , ir heart failure. List only one Immediate Liuse (Final	cause on each line.						Onset and Death  3 Monlin	
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Division or Attending after death. Director: Afte	by d	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At I building, etc. (Special	iome, farm, i	street, factory, office		City or Tow		, riardirinate italia	
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To the Hospital within 24 hours at To the Funerial	completely tilled	edical	29a. Certifier 1 A Certifying Phys (Check only 2 Medical Examir one)	ner: On the basis of examinand manner stated.	ation and/or	investigation, in my opinior	n, death occur	rred at the time, o	date and place, and	due to the cause(s)	
o the ithin 2	omple	Mec	29b. Signature and title of certifier			29c. License nun	nber		29d. Date signed (A	_	
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(5)	00		30. Name and address person who co	- 4	om 23a) (Typ	e, Print)	٨	ſ.,			
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-	Dhysish	<b>4</b>	1. Decedent's Name (First, Middle,	Last)					2. Date of Month		ay Year	3. Time of Death	
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4	Funeral			1. Sex 7. Agr	e (In yrs. last birt	thday)	If Under 1 Year	If Under 24 Hrs Hours Min.		Birth Day, Year		thplace (State or Foreign ountry)	
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-	or 28e	Director	10e. Street and Number				10f. Zip Code			10g. C	itizen of What C	ountry?	
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	items items	Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married	12. Was Decedent Amed Forces? 1 XYes 2 □		IS. W	as Decedent of H Yes, specify Cuba	an, Mexican, Puer	o Rican, etc.)	140-	Black, Whi		
920	be filed within 72 hours after death with the Maryland bytylene.  d other than "natural", or items 23a or 28e-f ehow do other than "natural", or items 23a or 28e-f ehow event, the Wadical Exam per must be natified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	☐ Yes 2 🗓 No	Specify:			Specify:	WHITE	
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Maryland 21215-0036			19a. Informant's Name/Relationshi		i		Address (Street			-			
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*			23a. Part1. Enter the disease, or c shock, or heart failure. List of	omplications that caused nly one cause on each li	d the death. Do r ne.	not ente	r the mode of dyir	ig, such as cardia	or respirator	y arrest,		Approximate Interval Between Onset and Death	
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ō	Physic this aral dii	ī.	1 Yes 2 7 No  27. Manner of Death	28a. Date of Inju		Time of	3 DOA 28c. Injur Wor	4 🗆 (NUISII)9 I			6 □Other (Specured	ecify)	
o	ath. r: Afte	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		iy rear)	Injury		Yes 2 □ No					
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	pital ours al eral D		29a. Certifier 1 Certifying	Physicien: To the best	of my knowledge	e death	occurred at the til	me date and plac	e, and due to	the cause	s) and manner a	s stated.	
	To the Hospital or within 24 hours afte To the Funeral Dire completely fillsd in t	edicai		xaminer: On the basis of and manner st	of examination an								
	To the within 2 To the complet	W	29b. Signature and title of certifier	101			29c. Licens				ate signed (Mon		
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	5		30. Name and address of person w	no completed cause of c	S Ta 2 2	(Type, F	Print)	Frostble	75 1-11	) 210	~3>		
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*	Regist	rar	DEC 0 2	2005	se B.	1 State of the sta							

			For State Registrar	State of M	<b>1</b> arylan		artment rtificate				-	giene Reg. No.	005	)	39032	)
			Decedent's Name (First, Middle,	Last)							2. Date of De			ar	3. Time of Death	1
	Physicia /Medic		MARY ELIZABETH	STEBBING			,				Novemb				12:02 p	o <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and number	r)		4b. City,	Town, or	Location of	of Death		4c.	County of I	Death		
			Laurel Regional 5. Social Security Number		ge /le vrs /	ast birthday)	Lau If Under		If Under	24 Hrs.	8. Date of Bir				orge's ace (State or Fore	ian
	Funeral Director		216-16-5561	1□ M 2\\ F	80	Yrs.	Months	Days	Hours	Min.	Nov. 1	iy, Year)		Count	land	ign
	ъ		Usual Residence of Decedent								110 11	7, 12				
	nrylan show	_	10a. State 10b. County			, Town or Lo								10	od. Inside City Lim 1 X Yes 2 ☐ I	
	he Ma	Director	Maryland Anne A	rundel	Tra	cey's	Land:					10a Citia	zen of Wha	1 Court		
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တ	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than Adical Examinar must be notilied at	by Funeral	1 ☐ Never Married 2 ☐ Marrie	Armed Forces d 1 ☐ Yes 2 🛭			If Yes, spec 1 ☐ Yes		n, Mexican		Rican, etc.)		Black, V			
Ö	irai', c	dby	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	:		10 165 4	2 <u>1</u> 21 NO	Зреспу.				Specify:	Whi	te ————	
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<u>lar</u>	uld be Venta vrked itic av	To B	Clarence Peacoc	k					Mabe	el De	arstei	n				
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked othar than "natural; or items 23a or 28a-f show any injury or other traumatic avant, Ita Modest Examinating an Annes. 2006.		19a. Informant's Name/Relationshi	o (Type, Print)				,			al Route Numb					
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Baltimore,	ages to to to or or		1 X Burial 2 Deremation 3		e c	emetery, crei	matory or o	ther place	1							
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Ba	Depriment important		> taline	11/14							ue, Hya			-		
			23a. Part1. Enter the disease, or c shock or heart failure. List of	omplications that cause	ed the death	n. Do not ent	ter the mod	e of dying	g, such as	cardiac	or respiratory a	rrest,			Approximate Interval Between	
	Physician :		Immediate Cause (Final disease or condition	_a Metast		[ntra=	ahdom	inal	Mali	enar	t Lympl	homa			Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or a					110011	0						
į,	Examine	_	Sequentially list conditions,	b	e a consolu	ianca off								-		
	ted nsit	nine	Sequentially list conditions, if any, leaving to minimal cause. Enter Underlying Cause (Disease or injury	Does to the s	a di contraggi	serios ou										
Ć,	execu n and ial-tra	Exar	that initiated events resulting in death) Last	c. Due to (or a	is a consequ	uence of):										
8760,	icate be executed physician and s the burial-transit	dical Examiner		d												
9	ntifica ng ph s as th		IF FEMALE:													
Вох	death certific e attending pl ed for use as t	lan/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 🗌 Fetal	death 3	□Ectopic pr					2	23d. Date of delivery  Month Day Year			
0	0 0 2	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□ Unknown		eath 5∟	Other (sp	өсту)								
Δ.	requires that the de leen signed by the a hould be detached t	by Physician/Me	Part II. Other significant condition	s contributing to death	but not resi	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did t	obacco us	se contribu	te to the	a cause of death?	
rds,	ed be							_			10	Yes 2 🛚	<b>∑</b> No 3[	] Proba	ibly 4 🗆 Unknov	wn
Record	> 0 0	Completed									24a. Was		24b. Wer	e autop	sy findings availal	ble
Re	9 4	шо									auto perfo	ormed?	deat	to com h? Yes :	pletion of cause o 2□ No	П
Vital	iician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o					
of V	hys	P	1 ☐ Yes 2 🗓 No	Hospital: 1 🗓 Inpa		ER/Outpatier			4 🗀 140		me 5 Resi			Specify	)	
o uc	ling P	inol iii	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of In (Month, E	jury Day Yea <i>r)</i>	28b. Time o Injury	f 2	8c. Injury Work	rat ∢? Yes 2.⊟ı		28d. Describe	how injury	occurred			
Division	Attending r death. actor: After by the fune	icat	2 Accident investiga 3 Suicide 6 Could no	ot be and Blace of I	niury - At ho	me, farm, sti			162 5		28f. Location (	Street and	i Number o	r Rural	Route Number,	-
Ω̈́	or Attending Patter death. I Diractor: After to in by the funera	Certification:	4 Homicide determin	building,	etc. (Specify	()	,,	,			City or To					
	To the Hospital or At within 24 hours after of To tha Funaral Dirac completely filled in by		29a. Certifier 1 X Certifying	Physician: To the bes	st of my kno	wledge, deat	h occurred	at the tim	ne, date an	nd place,	and due to the	cause(s)	and manne	r as sta	ited.	
	To the Howithin 24 Fo tha Fuston	edical	(Check only 2 Medical E one)	xaminer: On the basis and manner		tion and/or in				un occurr	ed at the time,				-	
	To the within To that comple	Σ	29b. Signature and title of certifier	-011	10		290	. License D23					signed (M		)ay, Year) • 2005	
^			7 0000			-		223	, 40			MOV	cmner	10	, 2003	
K	-6/		30. Name and address of person w Martin Weltz, M					ive,	Gree	nbe1	t, Mary	land	2077	0		
	Sta	ite	31. Date filed (Month, Day, Year)	A2 Regis	trar's Signa	ture .					·				-	
	Regist		NOV 1 6 20	5 Seene	, J.	Appe	w									

**AEM** 05-07640 Danny R. Stiger

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		د	1 - For State Registrar	State of Mary		artment of I rtificate of			enell ()	39033	
×.	Physic		1. Decedent's Name (First, Middle, La Danny R.	st) Stiger				2. Date of Death Month November	1	3. Time of Death 10:27 P	
	/Medi Examii Funeral			Hospital Sex 7. Age (In	or Location of Death shington If Under 24 Hrs.	8. Date of Birth (Month, Day,	4c. County of Death  Prince Ge Year)  9. Birthy	Death  George's  Birthplace (State or Foreig			
h	Director		Usual Residence of Decedent  10a State Maryland P.G.	100	23 Yrs.	Months Days		July 4	, 1982 De	elaware  10d. Inside City Limits	
	death with the Maryland ims 23a or 28e-f show	Director	10e. Street and Number		Distric	Heigh	ts	10	g. Citizen of What Cour	1 <b>∑</b> Yes 2 □ No	
	eath with	eral Di	8009 Daniel Di		in II C 12	20	747		U.S. A	A.	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. importent: if item 27 is marked other then "natural", or items 23a or 28e-f show any injury or other traumatic event, If a Medical Examination must be notified at once.	by Funeral	11. Marital Status  1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		was Decedent of the lift Yes, specify Cub	Hispanic Origin? (Sp. an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	Black, White, etc.  Specify: Black		
Maryland 21215-0036		Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		16a. Dece (Give life C_	dent's Usual Occu kind of work done DO NOT use retire Lerk	pation during most of work ad)	ing	6b.Kind of Business/In Private E		
land 2		To Be Co	17. Father's Name (First, Middle, Last Danny Ray Pr	ice- Witte	n		18. Mother's Name Verna	e (First, Middle, M Stiger	,		
, Mary			19a, Informant's Name/Relationship, Danny Ray Pri		800	9 Danie	el Drive	al Route Number, Distri	City or Town, State, Zip ct Height	Code) 20747	
Baltimore,			20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State		esition (Name of matory or other pla 1 Memori	!		Oc. Location - City or To Suitland,		
Balt			21. Signature of Funeral Service Lice	20 Comson 7	22	Robinso	ess of Facility On Funera Washin	l Home	c!32308th	St.N.W.	
	Physician /Medical		23a. Part / Enter the disease, or consider, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	polications that caused the one cause on each line.  Dunshor  Due to (or as a core	t would	er the mode of dyi		or respiratory arres	st,	Approximate Interval Between Onset and Death	
*	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Use to for as a consequence of j.  Use to for as a consequence of j.  Use to for as a consequence of j.							
68760,	tificate be executed g physicien and as the burial-transit	edicai Exa	Due to (or as a consequence of):								
P.O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and oage 2 should be detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1  Live birth 2 4 Pregnant at time 9 Unknown	23d. Date of delive Month	ery Day Year					
ords, P	w requires that been signed b should be deta	<u>ि</u> र्द	Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause giv	ven in Part I.		cco use contribute to the	ne cause of death?	
	Physicien: The law re this certificete has bee ral director, page 2 sho	Completed	24a. Was an autopsy prior to death?  1 Xyes 2 No 1								
f Vita		To Be	25. Was case referred to medical examiner? 1. Yes 2 □ No	Hospital: 1 ☐ Inpatient	2 JER/Outpatier	t 3□ DOA OU	26. Place of Death	1	ce 6 ☐Other (Specifi	v)	
Division of	ending eth. or: After ne fune		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Yea	28b. Time of	28c. Injui		Sub-yes		,	
Divis	ital or Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (Sp		eet, factory, office	281. Location (Street and Number or Rural Route Number, City or Town, State) FORM Dr. (his has left)				

To the Hospital or Attend within 24 hours efter deeth To the Funeral Director; completely filled in by the f State

30 Name and address of person w d cause of death (Item 23a) (Type, Print)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 XMedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

OCME

November 12, 2005

111 Penn Street, Baltimore, Maryland 21201

Registrar

29b. Signature and title of certifier

29a. Certifier

31. Date filed (Month, Day, Year)
NOV 1 6 2005

ASYA SOLOGUB 05-07651 RKD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death NOVEMBER 12, 2005 **Physician** SOLOGUB 6:59A. Asva /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES LAUREL REGIONAL HOSPITAL LAUREL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | Oct Month 1 2 y, Year 930 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Months Days Ukraine 75 218-41-1198 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Importents: If Item 27 is marked other than "naturel", or Items 23e or 28a-1 show any injury or other treumatic event, the Marical Examilier must be notified at once. Burtonsville MD Montgomery 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20866 #31 3922 Blackburn Lane Ukraine Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. ☐ Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 White þ 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pediatrician Medicine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dina Zingerman Mark Barinshtein 19a. Informant's Name/Relationship (Type, Print)
Yelena Sologub / daughter 19b. Mailing Address (Street and Number of Rural Route Number, City of Town, State Zie Gode) 3971 Ballet Way, Burtonsville, MD. 20866 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date 20c. Location - City or Town, State 4 injury 1 ☐ Burial 2 🖾 🛣 regnation 3 ☐ Removal from State Metropolitan Crematory Nov.15, 2005 Alexandria, VA 4 ☐ Donation 5 ☐ Øther (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive atherosclerone cardoscircular disease Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No .3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 Yes 2 🗆 No To the Hospital or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3□ DÓA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 20 MO O.C.M.E. NOVEMBER 13,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Taisha Z Circenhero M.D. 111 PENN STREET BALTIMORE MARYLAND 21201 31. Date filed (Month, Day, Year) NOV 1 6 32 Registrar's Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra AMEND#18perFH11/16/05, BMW, McCo Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Helen. SIMONS **Physician** 2005 6:40 P. M 14 Nov. /Medical 4b. City, Town, or Location of Death Annapolis 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Anne Arundel Medical Center Examiner Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min 8. Date of Birth (Month, Day, Year) Jan. 12, 1 5. Social Security Number 167-16-4704 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Yrs. 1922 PA. Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Exarcher must be notified at Severna Park Anne Arundel 1 XYes 2 No MD Director 10e. Street and Number 10f. Zip Code 21146 10g. Citizen of What Country? USA 43 W. McKinsey Rd. # 215 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XTNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐XNo Specify: þ 3 ♥ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Accounting Bookkeeper 12 18. Mother's Name *(First, Middle, Maid*en *Surname)*(UNKNOWN)

Ida <del>Creenfield</del> 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; if Item 27 is marked oth any Injury or other traumatic event once. Greenfield Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Schaughency / daughter 1304 Boxgrove Ct., Pasadens, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Locustwood Mem. Park Nov. 16, 2005 Cherry Hill, NJ 4 ☐Donation 5 20 ther (Sp. cify) 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 21. Signature of Fundral Station Licensee 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death ute Respiratory Immediate Cause (Final Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sic l Myoca Some tially list can flices if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to ( as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical use as i attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ō 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bγ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 🛂 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Anpatient 1 Tyes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Aft 5 Pending 1 ☐ Yes 2 ☐ No М 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of co D00058297 8

Registrar

State

Howhad Yours

31. Date filed (Month, Day, Year)

16

2005

Baltimore, Maryland 21215-0036

Records, P.O. Box 68760.

Division of Vital

Annapolis

MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Howard Young MD Anne Annale Medical Caula

32 egistrar's Signature

			1 - For State Registrar	State of Maryl		artmen <i>rtificat</i>			nd Mer		ene)	15 3	903	36	
10	Physici /Medic		1. Decedent's Name (First, Middle, Last)		Shen						Day 13	Year 2005	3. Time of 0416		
4	Examir Funeral Director		4a. Facility Name (If not institution, give s  The Chas Hope  5. Social Security Number 6. Sex	Kins Hos	pital vrs. last birthday) Yrs.	4b. City, 3 If Under Months	911	Location of If Under 2 Hours	Death  4 Hrs. 8. I	Date of Birth Month, Day,		9. Birthpl Count	ace (State o		
100	Q	_	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo					<u>-</u> , -,			od. Inside Cit	•	
	be filed within 72 hours after death with the Maryland hal Hygiene. ed other than "natural", or Kems 23a or 28a-1 show event, the Medical Exeminar must be notified at	ral Director	MD Montgomer  10e. Street and Number  14615 Edelmar Drive	-	Silver Spring  104. Zip Code 20906						10g. Citizen of What C				
9000	hours after de ural', or items	d by Funeral	1 Never Married 2 🖔 Married 3 Widowed 4 Divorced	2. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	s? If Yes, specify Cuban, Mexican, Puerto Ric						cify Yes or No-Rican, etc.)  14. Race - American Black, White, etc.  Specify: ASia				
Maryland 21215-0036	filed within 72 Hygiene. other then "nel ent, the Medic	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give		rk done d se retired	ritus			Colle		ustry		
ıryland	should be fill of Mental H marked oth	To Be	17. Father's Name (First, Middle, Last)  Hsing-Zhih Shen  18. Mother's Name (First, Middle, Maiden Surname)  Chi-Ruoh Hsu  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip C									Codel			
nore, Ma	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic enone.		Barbara Shen - Wiff 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Re	e 200 moval from State	14615 b. Place of Dispo cemetery, crer	Edelt esition (Nam matory or o	mar ] ne of ther place	Drive,	Silv Date	er Spr	ing,	Maryla ı - City or Tov	nd 209 vn, State		
Baltimore,	permit. Page Department important: If sny injury or once.		4 Donation 5 Other (Specify)  21. In ture of Fur and Service Lisense	antrait	10	2. Name an 40 Ro	d Addres	s of Facility	Simpl ike, R	e Trib Rockvil	ute 1e, M	ood, M arylar			
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Coronary  Due to (or as a cons	. Arter	^	e of dying		ardiac or res	piratory arres	t,	1	Approximate Interval Betw Onset and D	veen	
8760,	cate be executed by physicien and the burial-transit can	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons		•									
.O. Box 68	ne death certifi the attending hed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	2 Fetal death 3 Ectopic pregnancy at time of death 5 Other (specify)							ate of deliver		ear	
<u>α</u>	w requires that the base of the by should be detact	by	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	nderlying ca	luse give	n in Part I.		23e. Did toba		ntribute to the		ath? nknown	
tal Reco	iician: The law r certificate hes be rector, page 2 sh	Completed	25. Was case referred to medical						_   1			Were autops prior to compleath? 1 Yes 2	y findings avoietion of car	vailable use of	
Division of Vital Records,	Phys this al dii	tlon: To Be	examiner?	spital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28	Bc. Injury Work	r: 4 ☐ Nursi at ?	ing Home 28d. I	Death Check only one g Home 5 Residence 6 Other (Spa 28d. Describe how injury occurred					
Divisi	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	M 1 ☐ Yes 2 ☐ No  njury - At home, farm, street, factory, office 28f. Loc City						ocation (Street and Number or Rural Route Number, ity or Town, State)				
	To the Hospita within 24 hours To the Funeral completely filled	Medical	one)	cian: To the best of my ler: On the basis of exam and manner stated.	knowledge, death mation and/or inv	estigation,	in my op	nion, death	place, and d occurred at	the time, date	and place,	and due to the	ne cause(s)		
)		-	29b. Signature and fille of certifier  30. Name and address of person who con	McDs	tem 23a) /Time	6	License 165	- OO	0	- 1	Date signe	ed (Month, Di	2005	,	
	Sta Registr		- 11 1 2	North Wolf	re Stree	t, B	orlh	none	MD	2128	37				

DHMH 17 Rev 1/2001

Registrar

NOV 16

2005

			1 - For State Registrar	State of Ma	ryland / D	epartment Certificate	of Health and of Death	Mental Hygier	ne2005	39038
	Physic /Medi		1. Decedent's Name (First, Middle, La Levania	st) rown	State	n		2. Date of Death  1 Print 0 6	Day 05 <sup>ear</sup>	3. Time of Death 1510 м
	Examination Funeral Director	ner	249-25-4223	Hospital	(In yrs. last birtl 90 y	Ft.	Washingto Year   If Under 24 H Days   Hours   Mi	on P	ar)   Coi	
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD P G		10c. City, Town	or Location	ton			10d. Inside City Limits  X☐ Yes 2☐ No
	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or Items 23a or 28e-f show other treumetic event, the Marical Evantinal must be notified at	Funeral Director	10e. Street and Number  9702 Rider  11. Marital Status	Court 12. Was Decedent Ev		10f. Zip 0	ode 0744		Citizen of What Con	,
9600	nours after d ural', or Item I Evantinan	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2		(Specify Yes of No- erto Rican, etc.)	14. Race - Amer Black, White Specify: B	
21215-0036	d within 72 giene.	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12) 1 2	ducation ade completed) College (1-4or 5+		Decedent's Usual Give kind of work life. DO NOT use Cook	Occupation done during most of w retired)	rorking	rivate	ndustry
Maryland	hould be file d Mental Hy markad oth netic event,	To Be C	17. Father's Name (First, Middle, Last Henry Br 19a. Informant's Name/Relationship (	own	101	Mailing Add	Levani		n Midd	leton
re, Mai	s 1 and 2 st if Health and item 27 Is n other treun		Erie Rambert/ 20a. Method of Disposition	Daughter	970		Ct., Ft	Rural Route Number, City  . Washing Date 20c.		20744
	permit. Pages Department of I Importent: If ite any injury or of		1 🔀 Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special Service Lice)  21. Strature   Funeral Service Lice	v)	Resurr	ection 22. Name and	Cem. 11/	ylor's Fu	inton, l neral Ho	ome
	Cate be executed  Medical  Medical  The burial-transit	al Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line	atory consequence of Shock consequence of ation	If $722  \mathrm{N}$ at enter the mode of Failure ():	Capitol of dying, such as cardi	St. NW W.	ashingt	Approximate Interval Between Onset and Death
O. Box 6	death certifi e attending d for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 \overline{\text{ZNo}} 0 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 ☐ Ectopic preg			23d. Date of deliv Month	ery Day Year
Hecords, P.	w requires that the sbeen signed by the should be detached	by	Part II. Other significant conditions of Previous Uros				se given in Part I.		use contribute to t	he cause of death?
_	The law ate has b page 2 st	Completed	Dementia					24a. Was an autopsy performed? 1 ☐ Yes 2 🖾 N	death?	psy findings available impletion of cause of 2 No
Ĕ	Attanding Phy or death. ector: After this by the funeral d	ertification; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Y	'ear) 28b. Tin	М	Other: 4 Nursing Injury at Work? 1 Yes 2 No	eath (Check only one)  Home 5 Residence  28d. Describe how inju  28f. Location (Street a City or Town, Sta	ury occurred and Number or Rura	
ם	spite ours iere	edical Cer	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of	ny knowledge, o	death occurred at to or investigation, in	he time, date and plac my opinion, death occ	e, and due to the cause(	s) and manner as s	tated. of the cause(s)
	To the Hos within 24 hr To the Fun Completely	Σ	29b. Signature and title of certifier  Source  Who  30. Name and address of per so who	Completed cause of dear	h (Item 23a) (Ti	D (pe. Print)	icense number 0 0 2 6 2 6 2	11/	ate signed ( <i>Month</i> , 15/2005	
	Sta Registr	tė	Samuel J. Klein 31. Date filed (Month, Day, Year)	32. Registrar's	1711 I	ivings	ton Rd.,	Ft. Washi	ngton,	MD 20744
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 39039 1 - Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2005 Rosa Samuel November 7:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 1311 Darlington St. Forestville Prince George's 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb. 15, 1 Funeral 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 □ M 2 X F Months Days Min. Hours Director Yrs. 579-38-4104 76 Alabama Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location irei', or itams 23e or 28a-f show Esaminer must be colified at 10d. Inside City Limits Director 1 XYes 2 No Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1311 Darlington St. 20747 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 □ Divorced Specify: Black "neturel", Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) uring most of working Elementary/Secondary (0-12) College (1-4or 5+) 12thCook Government .. Pages 1 and 2 should be filed v tment of Health and Mental Hygie tant: If Itam 27 is markad other I jury or othar traumatic avant, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Daily Emma Davenport 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Samuel Reeder/Daughter 1311 Darlington St., Forestville, MD 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or once. ` 4 ☐Donation 5 ☐ Other (Specify) Harmony Memorial Park 11/14/2005 Landover, MD 21. Signature of Fu (e) al Service Licensee 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 MM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Dementia /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Cerebrovascular Disease Physician/Medical Examiner Due to (or as a consequence of) or Attanding Physician: The law requires that the death certificate be executed burial-transit Hypertension Due to (or as a consequence of): the IF FEMALE 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4☐ Pregnant at time of death Month Day Year 5 Other (specify) P.O. the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records. director, page 2 should be Breast Cancer 1 ☐ Yes 2 🛂 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 2 1 ☐ Yes 2 📉 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 X Natural 5 Pending safter death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To tha Funarai C (s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) HOVEMBER 10, 2005 ĸ. muli 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11700 Beltsville Dr., Beltsville, MD 20705 Francine Higgs-Shipman, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Been & fort

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** NOVEMBER 04, 2005 9:53A CYNTHIA CHRISTINE SUTTON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. Year, MAR. 16, 1 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1 □ M XXF 42 1963 WASHINGTON, DC Director 214 84 3090 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "neturel", or items 23s or 28a-f show emy injury or other treumetic event. The Medical Example Internative or confined at once. 10b, County XX Yes 2 No Director MARYLAND PRINCE GEORGES OXON HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20745 UNITED STATES 1115 WESTFIELD DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ₩ No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status XIX Never Married 2 Married 1 ☐ Yes XX No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH ADMINISTRATIVE ASSISTANT FEDERAL GOVERNMENT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) AURELIA JEFFRIES SYDNEY R. SUTTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLINTON, MD 20735 4901 SWEDEN COURT AURELIA SUTTON / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) WASHINGTON NATIONAL CEM. 11/11/05 SUITLAND, MD 21. Signalure of Funeral Service Licensee MARSHALL S FUNERAL HOME OF MARYLAND, INC. 4308 SUITLAND ROAD SUITLAND, MD 20746 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician 1HR. 38MINS. PULMONARY EMBOLISM - BILATERAL /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause F to the Jarying Cause (Disease or injury Due to (or as a consequence of) Examiner law requires that the death certificate be executed that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown DISECTING ANEURYSM-ASCENDING AORTA Completed 24b. Were autopsy findings available prior to completion of cause of death?

XX Yes 2□ No 24a. Was an autopsy performed? XIX Yes the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) aminer? Hospital: XX Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 □ No 2 ER/Outpatient 3 DOA ours after death.

nerel Director: After this of filled in by the funeral directors. 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death XXVatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) determined 4 \( \text{Homicide} \) 24 hours a Funerel I XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D26819 NOVEMBER 10, 2005 30. Name and address of preson who completed wuse of death (Item 23a) (Type, Print) 6005 LANDOVER ROAD #5, CHEVERLY, MD 20785 A.G. CHAUDRY, M.D. NUV 1 5 2005 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

				Department of Health and Menta Certificate of Death	
	Physic /Medi Exami	cal	roystan P.	, Mc	ate of Death Day Year Venue: 25, 2005 17: 26 M
	Funeral Director		5. Social Security Number  198-36-3225  Usual Residence of Decedent  6. Sex  1 M 2 F  77		te of Birth point, Day, Year) LY 11,1928 9. Birthplace (State or Foreign Country). Maryland  10d. Inside City Limits
	with the Maryl 3e or 28a-f sho if he notified a	Funeral Director	(VII)   TT = 70 F = 70 A	e Hall  101. Zip Code 21161	1 ☐ Yes ¾☐ No  10g. Citizen of What Country?  USA
9800	s 1 and 2 should be tiled within 72 hours after death with the Maryland (Health and Mental Hygiene. tiem 27 le marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Examiner must be notified at	b	3 ☐ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,  1 □ Yes 2♥ No Specify:	as or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
d 21215-0036	tiled within 72 h Hygiene. other then "net	Completed		Ba. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Farmer  18. Methods Name (First	16b. Kind of Business/Industry  Farming  Middle, Maiden Sumame)
Maryland	2 should be to and Mental He marked of eumetic ever	To Be	Roy Amos Smithson	Emma Jan  9b. Mailing Address (Street and Number or Rural Route	e Webb
Baltimore, M	permit. Pages 1 and 2 Department of Health a Importent: If item 27 le eny injury or other trei ance.		Gloria A. Smithson  20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  1 Departure 5 Other (Specific)	2601 Jolly Acres Road of Disposition (Name of lety, crematory or other place) au I United Delist Cem 2005	, White Hall, MD 21161
8760,	death certificate be executed  e attending physician and  for use as the burial-transit  and  and  and  and  and  and  and  an	dical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it arry, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition of the condi	e of):  By Company S. Main St., Steward of one of dying, such as cardiac or respired to the mode of dying, and the mode of dying, such as cardiac or respired to the mode of dying, and the mode of dying to the mode of	ratory arrest, Approximate Interval Between Onset and Death
.O. Box 6		Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal deat 4 □ Pregnant at time of death 9 □ Unknown	th 3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery  Month Day Year
Vital Records, P.	le law requires that the has been signed by th ge 2 should be detache	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting  Congestive Heavt Faul  Hupentensions	me	a. Was an 24b. Were autopsy findings available
	Physicien: The this certificate h al director, page	To Be	27. Manner of Death 28a. Date of Injury 28b.	26. Place of Death (Check Outpatient 3 DOA Other: 4 Nursing Home 5	autopsy performed? prior to completion of cause of death?  Yes 2 No 1 Yes 2 No
Division of	or Attendition death	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, f. building, etc. (Specify)	City	ation (Street and Number or Rural Route Number, or Town, State)
	To the Hospitel or within 24 hours after To the Funeral Dirticompletely tilled in its	Medical	29a. Certifier (Check only one)  2	pe, death occurred at the time, date and place, and due nd/or investigation, in my opinion, death occurred at the 29c. License number	to the cause(s) and manner as stated.  e time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	10		30. Name and address of person who completed cause death (Item 23a)	(Type, Print)	November 25, 2005 Manyland 21287
	△ Sta Registr		31. Date filed (Month, Day, Year) 32. Polistrar's Signature  DEC 0 2 2005	White Street Baltimore	e Manyland 21287

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year Physician NOV ZOU Mark Randal Sensel /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** March 20,1958 Days Hours 1₹M 2□F 47 Yrs. MD Director 219-66-0246 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show of Health and Mental Hygiene. Item 27 le marked other than "naturel", or Items 23a or 28a-1 show other traumatic event, the Micrical Examinat must be nutitied at 1 Yes 2 No Director Warfordsburg Fulton PA10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 190 Hunter Lane 17267 **USA** death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: þ Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Road Construction 10 permit. Pages 1 and 2 should be filled. Department of Health and Mental Heritang I in meritang injury or other. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be A. Vivian Younker Robert A. Sensel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42 Devinshire Road Hagerstown MD 21750
ce of Disposition (Name of Date 20c. Location - City o A. Vivian Sensel/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/28/05 Rehobeth Cemetery Mercersburg, PA 21. Signature of Funeral Service 22. Name and Address of Facility 141 West Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DISCAR CORONARY /Medical Due to (or as a consequence of) **Examiner** ATherosclavatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sicien and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the as IF FEMALE for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probebly 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 25 No 1 Yes 1 Yes : After this certifical tuneral director, p 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Inpatient 3 DOA Certification: To 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural after deeth.

I Director: Alf 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 1200112-Lac 2110 30. Name and address of person cause of death (Item 23a) (Type, Print) Mrs.Manzar Shafi 368 Mill Street Hagerstown, MD 21740

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Box 68760,

P.0.

Records,

Division of Vital

32. Registrar's Signature

05-7975 B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. JOHN SCHLERETH II State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year Robert Schlereth 26, 2005 4c. County of Death 12:30P ™ /Medical NOV Facility Name (If not institution, give street and number)
POTOMAC RIVER OFF CANAL PARKWAY 4b. City, Town, or Location of Death Examiner CUMBERLAND ALLEGANY tf Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jun 7, 1968 **Funeral**  Birthplace (State or Foreign Country) 1 M 2 F Hours Months Days Director MD 215-04-0473 37 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits MD Allegany Cumberland Directo 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 Fulton Street 21502 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □ Yes 2 □ No If Yes, Give Year or Dates: Persian Gulf Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Disabled 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Robert Schlereth Lydia Jean (Bishop) Schlereth ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health if Health other tra Lori Gordon sister 9 Joy Drive WV 26753 Ridgeley 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Importent: If Ite any Injury or ot once. 1 Burial 2 Commation 3 Removal from State Scarpelli Funeral Home, P.A. 11/28/2005 Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) MD 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signature of Funeral Service Licensee 108 Virginia Avenue: Cumberland, MD 21502 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Finat disease or condition resulting in death) Onset and Death Physician Head Injuries complicated by drowning /Medical Due to (or as a consequence of): Examiner Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical ettending physic IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) signed by the e Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 □ No hes autopsy performed? s after deau... rai Director: After this ce..... Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 X Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ð AT SCENE 27. Manner of Death 28a. Date of Injury FindMonth, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 🔲 Pending 2 Accident investigation 11/26/2005 1 ☐ Yes 2 No unk 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Potomac River off Canal 4 - Homicide

Division

ŏ within 24 hours a To the Funeral C completely filled 0

> State Registrar

MEON

29d. Date signed (Month, Day, Year) NOV. 27, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

200

(CC ASA) 111 PENN STREET, BALTIMORE, MARYLAND 21201

29c. License number

O.C.M.E

31. Date filed (Month, Day, Year) DEC 0

and title of certifier

29a. Certifier Check only 29b. Signature

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician **TIMBERS** 9:00 P M **JAMES** WILSON NOVEMBER 9. 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 605 Opus Avenue Prince George's Capitol Heights If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1☐**X**M 2☐ F 579-52-5820 65 Yrs. Nov. 16, 1939 Washington, DC Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-1 show The Medical Examiner must be notified at 1 X Yes 2 ☐ No Maryland Prince George's Capitol Heights Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 605 Opus Avenue 20743 USA filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 1956— If Yes, Give Year or Dates: 1970 14. Race - American Indian, Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify þ 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Salesman 12 Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic avent, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Eva Wilson Timbers Virginia Sr. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Belinda S. Wright (Daughter) 3412 Keystone Manor Place Forestville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/17/2005 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Riverdale Park Crematory \*4 □ Donation 5 □ Other (Specify) Riverdale, MD 22. Name and Address of Facility Jordan Funeral Service, Inc. 21. Signature of Funeral Service Licensee THEN CRAINS BUIL 4001 Benning Road, NF Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) CARDIO-RESPIRATORY ARREST Physician /Medical Due to (or as a consequence of): Examiner END-STAGE RENAL DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed DIABETES MELLITUS Due to (or as a consequence of) physician a s the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) the 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 X No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient Certification: To 1

Yes 2 □ No 3 DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No М investigation 2 Accident Diractor: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by t 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated, 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier NOVEMBER 14, 2005 #MD 30709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VAMC, 50 IRVING STREET N.W., WASHINGTON, D.C. 20422/688 Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 6 2005 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

		4	For State Registrar	State of Ma	arylan		rtment of F		nd Mei		jiene	)5	39045
			Decedent's Name (First, Middle, Last	")					2.	Date of Dea	ıth		3. Time of Death
	Physici		Lloyd Tilghman	Uber, Sr					N	Month	R 20	Year	\$ 1211 M
	/Medic Examin	_	4a. Facility Name (If not institution, give		ſ		4b. City, Town, or	Location of				ly of Death	1
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W	Funeral		5. Social Security Number 6. Se	TM 2□F		ast birthday) Yrs.	Months Days	If Under 2	Min.	Date of Birtl (Month, Day	Year)	Con	place (State or Foreign intry)
#5	Director		214-18-4468 Usual Residence of Decedent		85	115.			0	8/15/1	920	Mary	land
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
	Mary i-f sh	ţō	MD Caroline			Dentor	1						1 X Yes 2 ☐ No
	r 288	Director	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	intry?
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V	r dea	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origi In, Mexican,	in? (Specif Puerto Ric	y Yes or No- an, etc.)		i <i>ce -</i> Amer ack, White	can Indian, , etc.
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ylan	should to the Ment amarked umatic	ဥ	Unknown						Jnkno				
Mary	C1 (0 = st		19a. Informant's Name/Relationship (7) Rachel M. Uber /				ng Address <i>(Street</i> • 2nd Str					n, State, Zi	p Code)
() o	1 and Health em 27 ther tr		20a. Method of Disposition	Броиве	20b. F	lace of Dispo	sition (Name of		Date		20c. Location	- City or T	own, State
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0 #	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of ≥ neral Service Licen		Gree		Cemeter  Name and Addre			2003	Greens	boro,	MD
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	/Medical		resulting in death)	Due to (or as	-	", "	- 0	1	116				
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	sit ad	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):	- 8			V			
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687	ficate physis the	edlc	`	d									
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œ.	death	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at			Ectopic pregnancy Other (specify) _	<u>'</u>			٨	lonth	Day Year
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<u>=</u>	r. The										2 <b>/</b> No	1 Yes	2 □ No
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ā	tal or rs afte al Dir	Cert	TIONIO GO	Dullang, or	o. (Opcon								
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edica	(Check only 2 Medical Exam	ysician: To the best niner: On the basis of	f examina	wledge, death	occurred at the tir	ne, date and pinion, death	place, and occurred	d due to the d at the time,	ause(s) and r	nanner as , and due	stated. to the cause(s)
	the thin 2. the fundamental th	Medi	one) 29b. Signature and title of certifier	and manner sta	ated.		29c. Licens				29d. Date sign		
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			30. Name and address of person who	C G C C C C C C C C C C C C C C C C C C	eath (Iter	n 23a) (Type	7-5		•		( )	21-8	۷
6-			30. Name and address of person who t	CO P	Setti (ital	Lour (rype,	a poll	203	X No	, j4	0	162	9
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ature	( P -1 10)	-					1
0	Regist	rar	NOV 2 3 2005	12200	A.	Lance	P. P.						

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Ne. ecedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** San 2005 /Medical 4c. County of Death Name (If not institution, give street and number) Town, or Location of Death **Examiner** ne erter town Year If Under 24 Hrs. 8. Date of Birth Month, Day, MAY 20, If Under 1 Birthplace (State or Foreign Country)
 IRELAND (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🛱 F 162-05-5186 93 **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than "natural", or Items 23e or 28e-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or Items 23e or 28e-f ehow event, the Medical Examinar must be notified at MD KENT 1 ☐ Yes 2√☐ No ROCK HALL Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7071 ROCK HALL ROAD 21661 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status I □Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL ASSEMBLER MANUFACTURING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JOHN MONTGOMERY MATILDA MORRISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SCOTT VANSANT/HUSBAND 7071 ROCK HALL ROAD, ROCK HALL, MD 21661 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ō CHESAPEAKE CREMATORY NOV.11,2005 STEVENSVILLE, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee PELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEER ROAD, CHESTERTOWN, MD 21620 any in Fella rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only 115 cause in each line. Approximate Injerval Betw Immediate Cause (Final disease or condition **Physician** nmon /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): the attending physician are hed for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4□Pregnant at time of death 5 Other (specify) signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. g No 3 Probably 4 □Unknown 1 Tyes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA this 28a. D te f Injury (Month, Day funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After : Year 1 Natural 2 Accident 5 Pending М 1 ☐ Yes 2 ☐ No investigation in by the f Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel within 24 hours a To the Funeret I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 4 2005

21620

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Donnie Wayne Woodard 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 717 Hoppers Lane Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country) Oct. 25, 1946 Virginia Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days Months **№** M 2 🗆 F Yrs. 282-42-2701 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 XYes 2 ☐ No Harford Havre de Grace 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 717 Hoppers Lane 21078 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1976-93 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Military U.S. Army 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Carl Woodard Francis Clark 19b. Mailing Address (Street and Number or Eura) Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Woodard (Spouse) 731 West Bel Air Ave. Aberdeen, MD 21001 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State A. Ferris & Co. 11/14/05 4 □Donation 5 □ Other (Specify) West Chester, PA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Certonosolerotic Cardiovasculor Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1□ Yes 2X No 1 Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

/Medical **Examiner** attending physician and for use as the burial-transit Box 68760 Division of Vital Records, cate has to this After Director: / Medical To the Fun completely f 24 within

**Physician** 

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Director

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Certification:

Examiner

**Funeral** 

Director

item 27 is marked other than "naturel", or itams 23e or 28e-f show other traumatic event, the Medical Examiner must be multified at

Department of Heali Importent: If item 2 eny Injury or other once.

**Physician** 

al Hygiene.

Baltimore, Maryland 21215-0036

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner' 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

Registrar

who completed cause of death (Item 23a) (Type, Print)

29c. License number

30. Name and address of po

BALTO Md 21222 EXABIRD AVE

29b. Signature and title of certifier

			1 = State Registrar		Cei	rificate of	Death	Reg.	No.	39048
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Arthur Marvin Wh	eatman,	Jr.			2. Date of Death Month NOV 19	Day Year 2005	3. Time of Death 8:00 A M
	Examin		4a. Facility Name (If not institution, give str 308 Kerr Avenue	reet and number)		4b. City, Town, o	or Location of Death		4c. County of Death Caroline	
-	Funeral		Social Security Number 6. Sex		yrs. last birthday)	If Under 1 Year Months Days				ce (State or Foreign
	Director			M 2 F 74	Yrs.	Months Days	Hours Will.	8. Date of Birth (Month, Day, Yo 5 / 15 / 19	31	"DE
land	show at at		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ocation			100	d. Inside City Limits
e Mary	de 1 sh	ctor	MD Caroline		Denton					Yes 2 □ No
with the	or 28a-f by rutifie	Director	10e. Street and Number 308 Kerr Avenue			10f. Zip Code 21629		10g	. Citizen of What Countr USA	y?
leath v	ns 23e	eral		2. Was Decedent Ever	in U.S. 13.1		Hispanic Origin? (Spec an, Mexican, Puerto R	cify Yes or No-	14. Race - America	
72 hours after death with the Maryland	el', or Itar Examiner	by Funeral	1 Never Married 2 X Married 3 Widowed 4 Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	- 1	If Yes, specify Cub 1 ☐ Yes 2 🛣 No		lican, etc.)	Black, White, et	asion
72 ho	'naturel', dical Exa	eted	15. Decedent's Educa (Specify only highest grade	ation completed)	16a. Deced (Give	dent's Usual Occup kind of work done	pation during most of workin id)	g 16	b. Kind of Business/Indu	istry
filed within	than '	Completed	Elementary/Secondary (0-12) 11 H.S. GRAD	College (1-4or 5+)	1		ngineer		manufactu	ring
should be filed	l Health and Mental Hygiena. item 27 is markad other than "naturel", or Itams 23a or 28a-f shov other treumatic event, the Medical Estarinar must be notified at	To Be Co	17. Father's Name (First, Middle, Last) Arthur Marvin W	heatman,	Sr.		18. Mother's Name Ruth Eve			
2 shou	and M Is mar eumat	-	19a. Informant's Name/Relationship (Type			,			ity or Town, State, Zip C	Code)
and	tealth im 27 har tr		Jean E. Wheatman	·	308 . Ob. Place of Dispo		e., Dento		21629 c. Location - City or Tow	n State
Pages	nt of H		20a. Method of Disposition  1 □ Burial 2 ★ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)		cemetery, crei	matory or other pla	ory 11/21		over, DE	II, State
armit. P	Department of h Important: If ite any injury or of		21. Signature of Funeral Service Licenses						n, MD 216	544
Ph	ysician Medical kaminer		23a. Part 1. Enter the disease, or complic shock, or heart failur. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a co	MYOC Insequence of):	ter the mode of dyi	ng, such as cardiac or	respiratory arrest	í	Approximate nterval Between Onset and Death
sate be executed	ng physicien and as the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a co						
o coc o	been signad by the attending p should be detached for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	ic. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc Other (specify)	у		23d. Date of delivery Month D	
s that t	sign <b>ad</b> by I be detac		Part II. Other significant conditions cont	ributing to death but no	ot resulting in the u					/ Day Year
nire C	_ =	ete				inderlying cause gr	ven in Part I.		co use contribute to the	cause of death?
The law requires	ete has been page 2 should	ompl				inderlying cause gr	ven in Part I.	1 Yes  24a. Was an autopsy performe	2 No 3 Probal	cause of death?
VICION: The law requires	sertificete has been ector, page 2 should	Be Completed	25. Was case referred to medical examiner?	vsnital-		Oth	26. Place of Death	1 Yes  24a. Was an autopsy performe 1 Yes 2  (Check only one)	2 No 3 Probai	cause of death?  bly 4 Zunknown  sy findings available pletion of cause of
ding Physicien: The law requires	h. After this certificete has been funeral director, page 2 shoulc	To Be	examiner? 1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending	ospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatier ar)  28b. Time o	nt 3□ DOA Oth	26. Place of Death her: 4 ☐ Nursing Hom	1 Yes  24a. Was an autopsy performe 1 Yes 2  (Check only one)	2 No 3 Probai	cause of death?  bly 4 Zunknown  sy findings available pletion of cause of
DIVISION OF VITAL DECOMES	after death. I <b>Director:</b> After this certificete has been d in by the funeral director, page 2 should	To Be	examiner? 1 Xes 2 No  27. Manner of Death	1 inpatient	28b. Time o Injury	nt 3 DOA Cti	26. Place of Death her: 4 □ Nursing Hom ry at rk? Yes 2 □ No	1 Yes  24a. Was an autopsy performe. 1 Yes 2 (Check only one) 1 Secribe how	2 No 3 Probal  24b. Were autops prior to come death? No 1 Yes 2  De 6 Other (Specify) injury occurred	cause of death?  bly 4 Munknown  sy findings available pletion of cause of
DIVISION OF VITAL INCOLUSE  Hospitel or Attending Physicien: The law requires	n 24 hours after death.  • Funerel Director: After this certificete has been iterly filled in by the funeral director, page 2 should	Certification: To Be	examiner?  1	28a. Date of Injury (Month, Day Ye building, etc. (S	At home, farm, str Specify)  y knowledge, deat amination and/or in	nt 3 DOA  f 28c. Inju Wo M 1  reet, factory, office	26. Place of Death her: 4 \sum Nursing Hom ry at rk? Yes 2 \sum No	24a. Was an autopsy performed to the control of the	2 No 3 Probal  24b. Were autops prior to come death? No 1 Yes 2  De 6 Other (Specify) injury occurred	cause of death?  cause of death?  bly 4 Hunknown  sy findings available pletion of cause of  No N/A
5 €	within 24 hours after death.  To the Funerel Director: After this certificate has been completely filled in by the funeral director, page 2 should	To Be	examiner?  1	28a. Place of Injury building, etc. /S  28b. Place of Injury building, etc. /S  ician: To the best of mer. On the basis of exand manner stated.	28b. Time o Injury  At home, farm, stripecify)  y knowledge, deat amination and/or in	nt 3 DOA  f 28c. Inju Wo M 1  reet, factory, office	26. Place of Death her: 4 \sum Nursing Hom ry at rk? Yes 2 \sum No  2 ime, date and place, a opinion, death occurre	24a. Was an autopsy performed to the cause of the cause of at the time, date	2 No 3 Probal  24b. Were autops prior to come death? 1 Yes 2  6 6 Other (Specify) injury occurred  2st and Number or Rural is and place, and due to to the signed (Month P.	cause of death?  cause of death?  bly 4 Lunknown  sy findings available pletion of cause of local pletion of cause (s)

DHMH 17 Rev 1/2001

Registrar

NOV 2 1 2005 American 15

			State of Maryland / Department of Health and  1 - State Registrer  State of Maryland / Department of Health and  Certificate of Death	Mental Hy	giene 005	39049
			Decedent's Name (First, Middle, Last)	2. Date of D	eath	3. Time of Death
	Physicia /Medic		WILLIE WALKER	NOVEME	BER 11 2005	6:03A M
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Dea	ath	4c. County of Deal	
Ш			WASHINGTON ADVENTIST HOSPITAL SILVER SPRING  5 Social Security Number 6 Sex 7. Age (In vrs. last birthday) If Under 1 Year   If Under 24 Hr	S Doto of B	MONTGOME	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 79 17. Age (In yrs. last birthday) 1 Under 1 Year 1 Under 24 Hr Months Days Hours Mir			hplace (State or Foreign untry) orgia
7			Usual Residence of Decedent	SEPTE	MDER ZO   Ge	
9	ahow	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits 1)X□Yes 2 □ No
2	or 28a-f ahow	Director	MD PRINCE GEORGE S LANHAM  10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	
-	ath with the Maryla 1236 or 28a-f ahov Ant be pulified at		8423 HAMLIN STREET APT G-3 20706		U.S.A.	ouritry:
1	nous arer death with the maryand tural, or Items 23e or 28e-f ahow all Exacilmet cast be mailled al	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	Specify Yes or N		
٥	or Iter		Armed Forces?  1 Never Married 2X Married   Armed Forces?   If Yes, specify Cuban, Mexican, Pue   1 Yes, Give   1 Yes, 2 No Specify:	erto Hican, etc.)	Black, Whit	e, etc.
	awinin /z nous aner de jiene. r then "netural", or items It a Modical Examination	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			LACK
9500-6121	"net "net	lete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of w	orking	16b. Kind of Business	Industry
	Hied within 72 Hygiene. othar then "nei ant, the Medic	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 12th CHEF		PRIVATE	
פר	nt than	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	ame (First, Middle	e, Maiden Sumame)	
XIai	snould be and Mental I smarked o umatic eva	To	SAM WALKER MAGGIE			
्रं क	raum		19a. Informant's Name/Relationship (Type, Print)  GATL WALKER/WIFE  19b. Mailing Address (Street and Number or F			
	ss 1 and 2 should of Health and Mer itam 27 is marke r other traumatic		20a Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City or	
Ö ,	rages nent of l int: If it		1 ⊠ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  FT. LINCOLN  11/	16/2005	BRENTWOOD,	MARYI.AND
	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Licensee / 22. Name and Address of Facility J			
ñ			1. D. Hahall 7474 LANDOVER ROA			D 20785
		3	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardischock, or heart failure. List only one cause on each line.	ac or respiratory	arrest,	Approximate Interval Between Onset and Death
	nysician	i li	Immediate Cause (Pinal disease or condition resulting in death)  a. CARDIO PULMONAL Y	ARRICIS	,	Onsot and Dough
	/Medical Examiner		Due to (or as a consequence of):  ATHEROSCIERODC CARDI	DVASCUL	AR DISTASE	
		- e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
	outed id ransit	Examin	that initiated events C.			
ģ	e exec lan ar urial-tı		resulting in death) Last Due to (or as a consequence of):			
8760	The taw requires that the death certilicate be executed attending bhysician and attending physician and page 2 should be detached for use as the burial-transit	dlcal	d			
ο X	leath certific attending p	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of del	ivery
ROX	atter d for L	iciar	23b. Was decedent pregnant in the past 12 menths?  1 ☐ Yes 12 No  1 ☐ Yes 12 No		Month	Day Year
J.	at the de by the a tached	hys	9 ☐ Unknown 9☐ Unknown			
Š.	res that igned b		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  DIABETES MELLINS, HYPENTENSION, ENLEPHAWPA		tobacco use contribute to	
Vital Records,	w requir been si shou!d l	Completed by				obably 4 Unknown
Sec.	Ine taw sate has b page 2 s	mple	STIZURE DISORDER, TOTAL CARE.	24a. Wa auto	s an 24b. Were at prior to death?	itopsy findings available completion of cause of
e i	ician: Ih certificate rector, pag	e Co	OF Was are referred to modified	1 ☐ Yes	e⊠No 1 ☐ Yes	2 No
5	/sicia s certi	0 8	examiner? Hospital: Other	eath (Check only Home 5 ☐ Res	sidence 6 Other (Spe	cify)
ס ו	og Phy terthi neral o	n: T	27. Manger of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurred	,
<u> </u>	andin sath. or; Afi he fur	atlo	2 Accident investigation M 1 Yes 2 No			
Division of	or Att fter de Siracte in by t	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or Ru own, State)	ural Route Number,
٠.	pital ours a eral C		29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and plan	ce and due to the	e cause(s) and manner as	stated
	e Hos 24 hc e Fun letely	edical	(Check only one)  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death oci and manner stated.			
1	To the Hospital or Attanding Physician: within 24 hours stater death. To the Funeral Diractor: Alter this certifies completely filled in by the funeral director; ()	Me	29b. Signature and title   certifier   29c. License number		29d. Date signed (Mont.	
	(n)		* K. Seryaer Simon D53367		11-11-20	03
	Color	)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	R. RAJAA	7	
	416	oto	18818, DARNESTOWN ROAD, SVITE: 202, GAITHERSDVAG, MD: 31. Date filed (Month, Day, Year) 2 32. Registrar's Signature	usts.		
	Regist	ate rar	NOV 1 5 2005 (Month, Day, Year) 32. Registrar's Signature			

		1	For State Registrar	State of Mar		artmer e <i>rtificat</i>				giene Reg. No.	15	39050
30			1. Decedent's Name (First, Middle, Last)						2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia /Medic		ROSIA C. WILSON							ber 0'S	3002	10.39 b w
	Examin		4a. Facility Name (If not institution, give st	0 0 1		4b. City,	110	Location of Deat	1	4c. Count	y of Death	
, ,			Sinai Hospital  5. Social Security Number 6. Sex		In yrs. last birthday	v) If Unde		MOY Q If Under 24 Hrs.	8. Date of Bir	th	9 Birthr	place (State or Foreign
	Funeral Director		10	M XXF	65 Yrs.	Months		Hours Min.	OCT . 24	y, Year)		place (State or Foreign htry) GINIA
ĸ.	7.5	-	229 52 7266 Usual Residence of Decedent		0.5				001. 2	1940	A T 177	JINIA
	yland		10a. State 10b. County	1	0c. City, Town or I	Location						10d. Inside City Limits
	B Mai	cto	MARYLAND		BALTIMO	RE						XX Yes 2 □ No
	death with the Maryland ims 23s or 28s-f ehow r munt be notified at	Director	10e. Street and Number			10f. Zi	Code			10g. Citizen of	What Cou	ntry?
	ath w		301 McMECHEN ST. #			1 Man Dans		L217	Incorfu Von as Na		ED ST	CATES can Indian,
	er de Item	Funeral	11. Marital Status  1 Never Married 2 Married	<ol> <li>Was Decedent Event Armed Forces?</li> <li>1 ☐ Yes XXNo</li> </ol>		If Yes, spe	city Cuba	spanic Origin? (S n, Mexican, Puerl	to Rican, etc.)	Bla	ick, White,	
50	s filed within 72 hours after death with the Marylan I Hygiene other than "natural", or teme 23s or 28s-1 show ont, I'm Medical Examinat must be notified at	by F	Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	XX No	Specify:		Speci	fy: BL	ACK
2-003p	2 hou		15. Decedent's Educ	ation (144.4)	16a. Dec	edent's Usu	al Occupa	ation during most of wo	duna	16b. Kind of E	Business/Ir	dustry
2 2	hin 7. 9. an "n	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT	ise retired	)	ixing			
7	ad wit	Completed	10TH		HO	OME HE	ALTH				ELF	
/land	be filed Ital Hyg od othe event,	Be	17. Father's Name (First, Middle, Last)						m <i>e (First, Middle</i>	, Maiden Suma	m <i>e)</i>	
		ို	JAMES NEWMAN		40). 14		. (С		JONES	or City of Tour	Ctata 7	- Code)
Mar	2 should and resum.		19a. Informant's Name/Relationship (Typ					and Number or Ri			i, Siaie, Zij	Code)
	s 1 and 2 should f Heelth and Mer item 27 te marke other traumatic		GERALD NEWMAN / SO  20a. Method of Disposition	N	20b. Place of Dis	MESQU position (Na	me of		DERN, MI	20c. Location	- City or T	own, State
وّ	Ø 0 - b-		XX Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	cemetery, cr	•			10/000	OT DILA		7.4
Baltimore,	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Specify)  21. Signature of Fund I Service License	θ	JERUSALE					OLDHA		
g	Dep impo		1. Mars	100		4308	AHLL	S FUNER	AL HOME	TLAND,	(LAND MD 21	, INC.
(6)	No.		23a. Part1. Enter the disease, or complice shock or heart failure. List only on	cations that caused th	ne death. Do not e							Approximate Interval Between
	Physician	1	shock or heart failure. List only on Immediate Cause (Final disease or condition		icatio	10 C	20	ASC	av			Anset and Death
	/Medical		resulting in death)		consequence of):		>				· ·	11
	Examiner		Sequentially list conditions, b	Diabe	tes	Me	11,4	tus_				Years.
	ם פ	Iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):	Ο.	. 7					Years
	ecute and -trans	Examln	Cause (Disease or injury that initiated events cresulting in death) Last	Moy b	consequence of):	Obe	214	4				16m12
8760,	icate be executed physicien and s the burial-transit	a E			,		,	)				
587	icate phys s the	edical	<b>\</b> d									
Box	death certifi e ettending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of	pregnancy					23d. D	ate of deliv	евгу
ŭ	death e ette d for	cla	in the past 12 months?	1 Live birth 2 4 Pregnant at tir		3 DEctopic p 5 DOther (s				N	onth	Day Year
Ö	at the de by the e	hys	9 Unknown	9LJ Unknown								
S, P	The law requires that the tte has been signed by the bage 2 should be detache	by F	Part II. Other significant conditions con	tributing to death but	not resulting in the	underlying	cause giv	en in Part I.				the cause of death?
ord	w requir been si should						<del></del>		10	Tes ZUNO	3 [] F10	bably 4 Junknown
Division of Vital Records,	e law I has bo ye 2 sh	Completed							24a. Was		Were auto prior to co death?	opsy findings available ompletion of cause of
		Co							1 Yes	2 <del>□ N</del> 0	1 ☐ Yes	2 No
Zii	ilcien: Thi certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Oth		ath Check only			
ō	ding Physicien: n. After this certific funeral director,	- To	1 Yes 2 No	1 🔲 inpatient			00	4 C INGISHING	Home 5 ☐ Res 28d. Describe	how injury occu		(hy)
o	ding th. After funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Injur	y M	28c, Injur Wor 1 []	k? Yes 2∐No				
S	or Attending Physicien: after death. Director: Atter this certifica in by the funeral director.	flca	3 Suicide 6 Could not be	28e. Place of Injur- building, etc.	y - At home, farm,	street, facto	ry, office		28f. Location	Street and Num wn, State)	ber or Rui	al Route Number,
á	safte safte of in t	Certification:	4  Homicide	building, etc.	(Specify)				Oily or 10	wii, Stato)		
	Hospit 4 hour Funera ely fille	edical (	(Check only 2 Medical Examin	sician: To the best of ner: On the basis of e	examination and/or	ath occurre investigation	d at the tir n, in my o	me, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and n date and place	nanner as , and due	stated, to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Med	29b. Signature and title of certifier	and manner state	ea.	2	9c. Licens	e number		29d. Date sign	ed (Month	, Day, Year)
	H 3 H 3		TK/Maron	11.10			201	056418		Noven	nloer	- 10 2005
	1-		30. Name and address of person who co	mp eted cause of dea	ath (Item 23a) (Typ	e, Print)						
	DE		K. Tonya Mason A	10 24011	N Belve	dere	Ave	- Balt	imore	MD	212	15.
2.0		ate	31. Date filed (Month, Day, Year)	32. Registrar	's Signature							
7	Regist	rar	NOV 1 5 2005	due 1	MARKE							

		•	For State Registrar	State of M	1arylan	•	artment of I				iene 0 0	5	39051
			1. Decedent's Name (First, Middle,	Last)						Date of Deal		Year	3. Time of Death
	Physicia /Medic			Thomas	Frede	erick 1	Wingfield		No	vembe:	r 11, 20	005	9:20 P. M
	Examin		4a. Facility Name (If not institution,			167	4b. City, Town,		of Death		4c. County of		31
			2013 Harbour G			I O / last birthday)	Annapo		24 Hrs. 8. [	Date of Birth	Anne A		place (State or Foreign
г	Funeral Director		577-34-4262	1MM 2□F	77	Yrs.	Months Days	Hours		Date of Birth Month, Day,		Cou	ginia
			Usual Residence of Decedent			-							
	arylar ehow	2	Md. Anne An	da1	100. Cit	y, Town or Lo							10d. Inside City Limits 1 ☐Yes 2 ☐ No
	the M	Director	Md. Anne Anne Anne Anne Anne Anne Anne Ann	under		AIII	apolis			1	Og. Citizen of W	hat Cou	
	ours after death with the Marylan raf, or itema 23e or 28a-f ehow Examirier must be notified at		2013 Harbour (	ates Drive	- Ar	t.167		21401			USA		•
	death ma 2	Funerai	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U		Was Decedent of I If Yes, specify Cub		igin? (Specify	Yes or No-	14. Race		can Indian,
9	or ite	E.	1 Never Married 2 Marrie	d 1 17 Yes 2 If Yes, Give	] No		1 ☐ Yes 2 ☑ No			11, 6.0.7	Specify:	c, White, Whi	
93	thin 72 hours after death with the Maryland ie. ie. man "natural", or Itema 23e or 28e-f ehow Modical Exertiner must be notified at	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates	: WWII		dent's Usual Occu						
<del>1</del> 5-	9 2	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	kind of work done  DO NOT use retire	durina mos	st of working		16b. Kind of Bus	3111022/111	dustry
212	× e t	шо	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Plas	ster & Dr	ywall			Constr	ucti	.on
b	be filed ital Hygie ed other	Be C	17. Father's Name (First, Middle, Landson No. 1		٦						Maiden Sumame	э)	
yla	should be and Mental marked c	၉	Herbert Nelso		La				ry Mari				
Maryland 21215-0036	2 8 9 10		19a. Informant's Name/Relationshi Sharon Janes				ng Address <i>(Stree</i> Harbour						
	s 1 and 2 of Health item 27 l		20a. Method of Disposition		20b. F	lace of Dispe	osition (Name of		Date		20c. Location - (		
OF.			1 ☐ Burial 2 ☐ Cremation 3				matory`or other pla Veteran'		.11–17	-05	Chelten	ham,	Maryland
Baltimore,	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service Li		Wto		2. Name and Addro Beall Fun		*	512 NW	Crain :	Hwy.	20715 Bowie, MD
			23a. Part1. Enter the disease, or c shock, or heart failure. List o	omplications that caus	ed the deat	h. Do not en	ter the mode of dy	ng, such as	cardiac or re	spiratory arr	est,		Approximate Interval Between
	Physician ·		Immediate Cause (Final disease or condition	. Lymph									Onset and Death 2 Years
	/Medical Examiner		resulting in death)	Due to (or a		uence of):							
	LXummer		Sequentially list conditions,	b. — Due to (or a	s a consec	uence of):						-	
	uted I Insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	S									
ć	be executed sician and burial-transit		that initiated events resulting in death) Last	C. Due to (or a	s a conseq	uence of):							
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9	artifica ing ph e as th	Med	IF FEMALE:		,								
Вох	death certifica attending ph d for use as th	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Feta	Ideath 3	□Ectopic pregnanc □ Other (specify) _	у			23d. Date Mon		ery Day Year
o.	that the de led by the a detached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		oatii St	_ Other (specify) _						
S, P	es that igned b be deta	by Pr	Part II. Other significant condition	s contributing to death	but not res	ulting in the u	ınderlying cause gı	ven in Part I	l.	23e. Did to	bacco use contri	bute to t	he cause of death?
rds	equire en sig ould b	ed b	EIU Sta	age Emphyse	======================================					1 XY	es 2 No	3 Prof	oably 4 Unknown
Record	e law requ has been je 2 shouli	piet								24a. Was a	sy pi	rior to co	opsy findings available impletion of cause of
H		Completed								perform 1 Tes		eath?	2 No
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			0:	har	e of Death (Cl				
of	Phys ral di	. To	1 ☐ Yes 2 ☐ No 27. Mann of Death	28a. Date of in (Month, L		ER/Outpatie	of 28c. Inju	iry at			ence 6 ⊡Othe ow injury occurre	-	(y)
	Attending Ph ir death. ector: Alter th by the funeral	tlon	1 Natural 5 Pending 2 Accident investiga		Jay Year)	Injury	Wo	ork? ]Yes 2. □	]No				
Division	or Attendil after death. Director: A in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determine	Zoe. Place of	Injury - At h etc. (Specia	ome, farm, st	reet, factory, office		28f.	Location (Si		or or Rura	al Route Number,
Ö	itai or A irs after ral Directed in by	Cer											
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical E	Physician: To the be xaminer: On the basis and manner	of examina	owledge, deal ation and/or in	nvestigation, in my	opinion, dea	nd place, and ath occurred a	t the time, d	late and place, a	nd due t	o the cause(s)
	To To E	M	29b. Signature and title of certifier	200-	Ann		0	se number	11/20	>	29d. Date signed	. /	1/ 200
	5		portion of	Jun 200	doct (	n 02c\ /==	Priot)	· · ·	1400		NOV	(	4 1001
	(3)		30. Name and address of person was a street of the street	ENDY A	n death (Iter	4 )	FENSE	H16	HWAY	ANO	VAPOLIS	M	121401-8915
	Sta Registi		NOV 1 5 200	5 Bleen	strar's Sign	Grow							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Williams Clarence, 2005 8:45 A November 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) Prince George's Cherry Lane Nursing Center Laure1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 XM 2□F Hours Yrs. South Carolina 75 Director 577-32-3723 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ?7 is marked other than "natural; or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director Cheverly Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. important: If item 27 is marked other than \*\*--\*. any injury or other traumant—any should be applied. 20785 United States 2903 Hillside Avenue Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Waiter Private 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fannie Mae Hammond Clarence Williams, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anthony Jones / Nephew 2903 Hillside Ave., Cheverly, MD 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 11/17/05 Landover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., DC 20019 luvar 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic Renal Physician /Medical Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner requires that the death certificate be executed ed by the attending physician and detached for use as the burial-transit Cause (Disease or lightly that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Coron 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy 1 Yes 1 Yes : After this certification : After this certific Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) 1□Yes 2□M6 Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending death. investigation 1 Tyes 2 Accident 6 Could not be n 24 hours after de ne Funeral Directo de Hetely filled in by the 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura MO 05 30. Name and address of pe Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

NOV 1 5 2005

**ORIGINAL** 

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

30. Name a address of person who completed cause of death (Item 23a) (Type, Print

6 2005

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

			For State Registrar	State of	of Marylar		artment of H tificate of I			giene nog. No. () () (5	39054
ı	Physici	an	1. Decedent's Name (First, Middle, John E.	Young,	Sr.				2. Date of Dea	r 31, 2005	3. Time of Death 10:00а м
	/Medic Examin		4a. Facility Name (If not institution,	give street and nu				Location of Deat		4c. County of Deat	th
			2302 Brooks Dr 5. Social Security Number	S. Sex	7. Age (In yrs.	(ant high do)	Foresty	7ille	8. Date of Birt	Prince Ge	
H	Funeral Director		218-24-2483	1 M 2 □ F	7. Age (myns.	Yrs.	Months Days	Hours Min.	(Month, Day	(, Year) Jack	thplace (State or Foreign unity) Inston, D.C.
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				10d. Inside City Limits
	a-f sho	ctor	Maryland Prince	Georges	I.	orestv	ille				1-□Yes 2□No
	with th	Directo	10e. Street and Number 2302 Brooks Dr.				10f. Zip Code 20747			10g. Citizen of What Co United Sta	
98	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I're Medical Evantitien must be nuffilled at once.	by Funerai	11. Marital Status  1 Never Married 2 Marrie	Armed F d 1∛∑Yes If Yes, G	2 ☐ No ive		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit	orican Indian, θ, etc.
Ö	tural,	ed b	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or [		16a, Dece	lent's Usual Occup	ation		16b. Kind of Business	ack
21215-0036	ithin 72 ne. nan "mar	Completed	(Specify only highest Elementary/Secondary (0-12)	Ť	) (1-4or 5+)		kind of work done of	_	rking		
d 21	filed w Hygier other th	e Cor	17. Father's Name (First, Middle, L	ast)		MIL	itary Ret		ne (First, Middle,	Governmen  Maiden Sumame)	. L
ylan	ould be Mental arked c	To Be	Robert Young					Rosie '	Thomas		
Maryland	d 2 sho th and 7 is ma traum		19a. Informant's Name/Relationsh							r, City or Town, State, 2 lboro, Md.	
ore,	ss 1 an of Heal Item 2 r other		Edith E. Young 20a. Method of Disposition	/ Wife		Place of Dispo	sition (Name of natory or other place	θ)	Date	20c. Location - City or	Town, State
Baltimore,	t. Page tment rtant: If rjury or		1 ☐ Burial 2 ☐ Cremation  '4 ☐ Donation 5 ☐ Other (Sp	sglity)	Arl		Nationa			Arlington,	
Ba	Depar Depar Impor any ir		21. Signature of Funeral Service	Censee	Moio	75 22	Alle vander 5538 Mar.	boro Pil	Euneral ke/Fores	l Homes, P. tville, Md.	A·20747
			23a. Part1. Enter the disease, or o shock, or heart ailure. List of								Approximate Interval Between Onset and Death
	Physician / /Medical		Immediate Cause (Rinal disease or condition resulting in death)	a. Itrt	(or as a consec	erotiz	- Hype	tensi	ve Hea	A Disea	~
	Examiner	7	Sequentially list conditions,	b	(or as a consec						
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to	(or as a consec	quence or):					
90,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to	(or as a consec	quence of):					
68760,	-	edical		d							
P.O. Box	The law requires that the death certificate has been signed by the attending I sage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live	utcome of pregnation birth 2 Feta Inant at time of conown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	quires that in signed b uld be deta	by	Part II. Other significant condition	s contributing to	death but not res	sulting in the ur	nderlying cause give	en in Part I.		bacco use contribute to es 2□No 3□Pr	
Records,	The law requir ste has been s page 2 should	completed							24a. Was a autop perfor	sy prior to death?	itopsy findings available completion of cause of
Vital	ysician: The is certificate hadirector, page	BeC	25. Was case referred to medical examinat?	Hospital:			Othe	00	th (Check only or	ne)	
on of	Jing Ph I. After th funeral	ion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending	28a. Date (Mor	Inpatient 2 of Injury oth, Day Year)	28b. Time of Injury	28c. Injun	4   Nursing F		ence 6 Other (Specow injury occurred	cify)
Division of	Dife o	Certification:	2 Accident investigation inves	ot be 28e. Plac	e of Injury - At h ding, etc. (Speci		eet, factory, office		28f. Location (S City or Tow	treet and Number or Ru n, State)	ıral Route Number,
	Fo the Hospital within 24 hours of the Funeral I completely filled	edicai C		xaminer: On the I						ause(s) and manner as late and place, and due	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	10			29c. License			29d. Date signed (Monti	
Δ	(1)		> talvade	13/10	374 3	20	Print)	0359	2-/ /	Vovember.	(0, 2005
1	12		30. Name and address of person was Solva dev Sy	INSTER,	3001	Hospi	tal Dry	vg Ci	lovely	November.	and
	Sta Regista		31. Date filed (Month, Day, Year) NOV 1 6 20	05	Registrar's Signa	ature	w		//	/	

			. For							Mental Hyg		egible.	
			1 - State Registrar			Cei	tificate d	of Dea	ath	Re	g. No.	05	39055
	Physici	an	1. Decedent's Name (First, Middle, Las Carl Bentz Zook	1)						Date of Deat Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	-44			4b. City, Tow		· · · · / D - · · ·	November			
	Examin	er	Shady Grove Adven				Rockvi		ition of Death			ounty of Dea	
	Funeral		5. Social Security Number 6. Se	x 7. Ag	e (In yrs. last birt	thday)	If Under 1 Ye	ear If U	nder 24 Hrs.	8. Date of Birth			thplace (State or Foreign
	Director		194-01-8809	ØM 2□F	91 、	Yrs.	Months Da	ays   Ho	urs Min.	Feb. 6,		4 Pen	nsylvania
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Lo	cation						10d. Inside City Limits
	Maryl -f ehc	to	Maryland Montgome	ry	Gaither								1 ☐ Yes 2 🗓 No
	r 28a	Irec	10e. Street and Number		I		10f. Zip Cod	de		10	g. Citize	on of What Co	ountry?
	23a c	Q le	401 Russell Avenue	, #612			208	77		Į	Jnite	ed Sta	tes
	tems	uner	11. Marital Status	12. Was Decedent Armed Forces?		13. \	Was Decedent	of Hispani Cuban, Me	c Origin? (Sp xican, Puerto	pecify Yes or No- Rican, etc.)	14	Race - Ame Black, Whit	
36	rs afte	y F	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		⊺⊡Yes 2🔀		ecify:		S	pecify:	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow fe Modical Extrallight at the ricillish at	ted	15. Decedent's Edu	ucation	16a.	Deced	lent's Usual Oc	cupation			6b. Kind	of Business	hite
215	thin 7;	ple	(Specify only highest grade Elementary/Secondary (0-12)	le completed) College (1-4or !		(Give lite. [	kind of work do DO NOT use re	one during tired)	most of work	king			of the
7	ygien ygien rer th	Con	_	4		ecti	cical E				Na	avy	
Maryland	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last)							e (First, Middle, N	laiden Si	umame)	
ž	d Mer d Mer marke	Ļ	S. Herman Zook  19a. Informant's Name/Relationship (T)	(no. Print)	10h	Maille	- Add /Ct-			Bentz	011		
S	ith an 27 io 1 traui		Marion T. Zook/ Sp							ra <i>l Route N</i> um <i>ber.</i> 512. Gait			MD 20877
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event. If a Modical Exercitival be relified at once.		20a. Method of Disposition						report to	Date 2	Oc. Loca	ition - City or	Town, State
Ē	Page Int: If		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	20b. Place of cemeter, St. Jo	hp	s Luth	eran	Nover	IDCI		eville sylvan:	•
a T	spertn sports sy nju		21. Signature of Funeral Service Licen	88	\	22	. Name and Ad	idress of F	acility De	Vol Funer	al H	Home,	ıa
	#Q E # 9		M/m/	UW		10	East 1	Deer	Park I	Orive, Ga	ithe		g, MD 20877
			23a. Part1. It et le disease, or comp shock, o he t failure. List only o	lications that caused ne cause on each li	the death. Do no	ot ente	er the mode of	dying, suc	h as cardiac	or respiratory arre	st,		Approximate Interval Between
98	Physician /Medical		Immedia vus (Fina disease or condition resulting in death)		PIRATO		ARR	EST					Onset and Death
	Examiner				a consequence o	,	LAOT	EA	11 110	E			2 days
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Вох	death atter	clan	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at	2 Fetal death		Ectopic pregna Other (specify)				230	d. Date of deli Month	ivery Day Year
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ord	w require									1 🗆 Yes	2 5	Vo 3□Pr	obably 4 Unknown
ပ္တ	law r	Completed								24a. Was an autopsy	2	24b. Were au	topsy findings available completion of cause of
Vital Records,										perform	No No	death?	2 □ No
<u> </u>	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:				O+		h (Check only one			
ö	Phys	٦. ا	1 Yes 2 No	28a. Date of Injur	v 28b. Ti		3 DOA	njury at		me 5 Residen			cify)
Division	nding ath. r: After e funer	Certification:	1 Natural 5 Pending 2 Accident Investigation	(Month, Da)	Year) In	jury	V	Nork? □Yes a			,,		
<u>NS</u>	after death Director: , In by the f	tific	3 Suicide 6 Could not be determined	28e. Place of Inju-	ury - At home, farr	m, stre	et, factory, offic	ce		28f. Location (Stre City or Town,	et and N	lumber or Ru	ral Route Number,
ā	ital or irs aft ral Di led in	Cer		Dullying, etc	. (Opecity)					City of Town,	Sialej		
	e Hosp 24 hou e Fune letely fil	ical	29a. Certifier (Check only one)  2 Medical Exami	ner: On the basis of	examination and	death /or inv	occurred at the	time, date	e and place, death occurr	and due to the cau	ise(s) an	d manner as	stated. to the cause(s)
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral	Medical	one) 29b. Signature and title of certifier	and manner sta	ted.			ense numb				igned (Month	
	F 3 F 8		· ·	ru mo				063					14,2005
	13		30. Name and address of person who co			Type F		042	127	140		1327	1110000
			POWLLIMI NADKA	RNI, M.D	, , ,	,	,	enter	Drive	, Rockvi	11e,	MD 20	0850
27	Stat	e	31. Date filed (Month, Day, Year) NOV 1 6 20	32 Registra	ar's Signature	do	elle )						
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	-	For State Registrer	State of	Maryland /					<i>I</i> lental Hy	711	05	39056
۰			, Last)							ath		3. Time of Death
		Shirley	A.	E	Badola	ato				c 3, 200	05 Year	7:35 A M
		4a. Facility Name (If not institution	, give street and num	ber)		4b. City, Town	n, or Location	of Death		4c. Co	unty of Death	1
		Genesis Elderca	re- Herita	ige Cente	er					F		
Funeral Director			6. Sex 7 1 ☐ M 2 🛣 F	7. Age (In yrs. last 76	birthday) Yrs.				8. Date of Bi (Month, Di July 7	th ay, Year) 1929	9. Birth Con MD.	nplace (State or Foreign untry)
pu >		Usual Residence of Decedent		10c City T	'oum or Los	action						10d. Inside City Limits
Aaryla f shov	ō		imore	Toc. City, 1								1 ☐ Yes 2 X No
the N	rect	10e. Street and Number					е			10g. Citize	n of What Co	untry?
3a or	0	6806 Crossway				21	222			US	SA	
ems 2	ıner	11. Marital Status	12. Was Deced	dent Ever in U.S. ces?	13. V	Vas Decedent o Yes, specify C	of Hispanic (	Origin? (Sp	pecify Yes or No Rican, etc.)	0- 14.		
s after	y Fu		ied 1 ☐ Yes :	No No					,	Sp		
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tem 2		20a. Method of Disposition	iiabbai	20b. Place	e of Dispos	sition (Name of					tion - City or 1	Fown, State
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permit. I Departm Importal any inju		21. Signature of Ameral Service	Liganye		22 72	Name and Ad Onnelly	dress of Fac Funer	al He	ome Of	Dunda]	k,P.A.	21222
		23a. Part. Enter the disease, or	complications that ca	used the death. [							LIK PILID .	Approximate Interval Between
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Examiner		Sequentially list conditions,	b. Hy	PER?	EN	SION	/			ع د ت د		
ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c		,	* /						
al-trar	xan	that initiated events resulting in death) Last	c. Due to (c	or as a consequen	(S / C)							
e be e	calE		La MA	LNGT	FRI	TICK						
tificat ng ph) as th	ledi			, , , , , , , , , , , , , , , , , , , ,								
ne death cer the attendir hed for use	ysician/N	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ○ No	1 ☐ Live bi	rth 2 ☐ Fetal de ant at time of death	ath 3 🗆					230	d. Date of deli Month	very Day Year
that the		Part II. Other significant condition	ons contributing to de	ath but not resultin	ng in the un	iderlying cause	given in Par	t I.	23e. Did	tobacco use	contribute to	the cause of death?
quires n sigr uld be	q pa								1 🗆	Yes 2□I	No 3□Pro	obably 4 Dunknown
he law red e has bee age 2 shoi	omplete								auto perf	ormed?	prior to death?	topsy findings available completion of cause of
lan: Triffical		25. Was case referred to medical					26. Pla	ce of Dea			, , , , , ,	2.00
hysici nis ce I direc	To E	1 Yes 2 No	Hospital: 1 🗆 Ir	patient 2 ER	/Outpatient	t 3 DOA	Other: 4	ursing H	ome 5 🗆 Res	idence 6 [	Other (Spec	ify)
ing Pl			g (Month	f Injury h, <i>Day Year)</i>	b. Time of Injury				28d. Describe	how injury o	ccurred	
ttend death stor: /	cat	3 ☐ Suicide 6 ☐ Could	not be	of Injury - At home	farm stre			No	28f Location	(Street and f	Jumber or Ru	ral Route Number
after Direction by	ertif	4 ☐ Homicide determ	buildin	ig, etc. (Specify)	o, raini, otie	set, ractory, onr	00					
e Hospita 24 hours e Funeral etely filled			Exeminer: On the ba	sis of examination								
다음다	. (1)									20d Date 9	igned (Month	
Neith Con	Ž	29b. Signature and title of certifie				29c. Lic	ense numbe	r	1	23d. Date s	e c	n, Day, Year)
To To	Me	29b. Signature and title of certifie	ox (L	Julka	. LI	29c. Lic	ense numbe $227$	188	-	12,	15/c	n, Day, Year)
or with	Me	29b. Signature and title of certifie  30. Name and address of person  Available 7 (2)	08/12	JUICA e of death (Item 23 2 Mar	( L(1) Ba) (Type, F		2) GCC	188 Di	endol	12,	15/c	n, Day, Year) 05 1222
	ding Physician: The law requires that the death certificate be executed to the death certificate be executed to the death certificate be executed to the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the attending physician and the death certificate has been signed by the deat	After this certificate has been signed by the attending physician and full may be detached to use as the burial-transit of page.  To Be Completed by Physician/Medical Examiner  To Be Completed by Physician/Medical Examiner  To Be Completed by Physician/Medical Examiner	The Hobitical Examiner  1. Decedent's Name (First, Middle Shirley  4a. Facility Name (If not institution Genesis Elderca:  5. Social Security Number  213–28–9329  10a. State  10b. County  10a. State  10b. County  10a. State  10b. County  10a. State  10b. County  10c. Street and Number  1	Physician / Medical Examiner    1. Decedent's Name (First, Middle, Last)    Shirley	The State State State State State Shirley A. Shirley A. Shirley A. Shirley A. Shirley A. Facility Name (If not institution, give street and number) Genesis Eldercare— Heritage Center S. Social Security Number 6. Sax 1 May 2 MF 7. Age (In yrs. last 1 M 2 MF 7. Age (In yrs. las	1. Decedent's Name (First, Middle, Last)	1- State Registere   Certificate of Registere   Certificate of State Registere   Certificate of Sharpedom's Name (First, Middle, Last)   Sharpedom's Name (First, Middle, Last)   Sharpedom's Sharpe	1- Sine Register   Certificate of Death	The State   1.0 - State   1.0	Physician   Phys	Physician   Considered Name (First, Microte, Last)   Shirley   A.   Badolato   Shirley   Shirley   A.   Badolato   Shirley   Shirley   A.   Shirley   Shirley   A.   Shirley   Shirley	1- State provision (Section 1)   Consideration Name (First, Micros), Last)   Control of Page 1)   Control of Page

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 2 per doc 850 12-30-05 bt and Montal Hygiens

			for State Registrar		State	т ма		pafitment of I e <i>rtificate of</i>		nd Mental H	ygiene Reg. No.	05	39057
3.4	Physici		Decedent's Name (First,     Barbara		ose	Bak	er			2. Date of E Month Nov	26Day	2005	3. Time of Death
	/Medic		4a. Facility Name (If not ins				<u> </u>	4b. City, Town, o	or Location of I			unty of Death	12:27PMM
1	- Z		Washingto	n Ad	ventist	Hos	pital	Takoma	Park			ntgome	
75.	Funeral		5. Social Security Number		Sex	7. Age	(In yrs. last birthd	y) If Under 1 Year Months Days	If Under 24				place (State or Foreign ntry)
SA	Director		236-74-0057		1 □ M 2 □ F		61 Yrs	Months Days	Hodrs		1, 194	4 West	t Virginia
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	r 28a-f	rec	10e. Street and Number				wasning	10f. Zip Code			10g. Citizer	of What Cou	X ntry?
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	r dea	Funeral Director	11. Marital Status		12. Was Dec	edent Evorces?	ver in U.S. 1	3. Was Decedent of H		n? (Specify Yes or N	0- 14.	Race - Americ Black, White,	
36	or it	by Fu	1 Never Married 2		1 ☐ Yes If Yes, Gi	2 X No		1 ☐ Yes 2 ☑ No	Specify:	donto modin, etc.)		ecify:	etc.
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D	al Hy I oth	Bec	17. Father's Name (First, M		)				18. Mother's	Name (First, Middle			7.
yla	Ment Ment arked atto	2	William Gree	n						ie Fox			
Maryland	12 should be filed within? h and Mental Hygiene. Fis marked other than? Iraumatic event, the Med	1	19a. Informant's Name/Rel					iling Address (Street				wn, State, Zip	Code)
e,	1 and Healti em 27 ther t	ļ	Garfield Gre 20a. Method of Disposition	en	(Brot	ther,		3 Grenada position (Name of	AVenue	e Oxon Hi		20745	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel; or iteme 23s eny injury or other traumatic event, the Medical Exant as must pince.		1 ⊠Burial 2 □ Crema	tion 3 E	Removal from	State	cemetery, c	ematory or other place	1			on - City or To	
ij	nit. P artme ortan injur;		4 ☐ Donation 5 ☐ Ott				Mt. Hop	e Cemeter		12-2-05	Marti	nsbur	, WV
Ba	Depar Impo		Luch	1.1	robox	10C	2	Brown Fr 327 W. 1	uneraĺ King St	treet Mari	insbur	e. WV	25401
			23a. Part1. Enter the disea shock, or heart failure	se, or con List only	plications that of	caused the	ne death. Do not	enter the mode of dyin	ig, such as cai	rdiac or respiratory	arrest,		Approximate Interval Between
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o	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4∐Pregr 9□Unkn		ne of death	Other (specify)				WOTE T	Day 18a1
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ital		BeC	25. Was case referred to me	dical					26. Place of	1 ☐ Yes  Death (Check only	2 No	1 🗆 Yes	2 L No
<u>&gt;</u>	hys dig	2	examiner? 1 ☐ Yes 2 🙀 No		Hospital: 1	npatient	2 ER/Outpat	ent 3 DOA Oth		ng Home 5 Res		Other (Specify	′)
ם	ding Ph th. After thi funeral		27. Manner of Death 1 Satural 5 □ P	ending	28a. Date (Mon	of Injury th, Day Y	(ear) 28b. Time			28d. Describe			
sio	tend death tor: A the fi	cati	2 Accident in	vestigatio				M 1 🗆	Yes 2 □ No				
Division	after of Direction by	Certification:	4  Homicide	etermined	28e. Place	of Injury ng, etc.	· At home, farm, : (Specify)	street, factory, office		28f. Location ( City or To	Street and Nu wn, State)	mber or Rura	l Route Number,
_	spital		29a. Certifier 1 🔀 Cer	tifvina Pł	vsicien: To the	hest of	my knowledge de	ath occurred at the tim	ne date and n	lace, and due to the	anuar(a) and		
	To the Hospital or Attending Pleasing 24 hours after death.  To the Funeral Director: After it completely filled in by the funera	edicai	(Check only 2 Medone)	lical Exer	niner: On the b	asis of e	kamination and/or	nvestigation, in my op	pinion, death o	occurred at the time,	date and place	e, and due to	the cause(s)
	To t Com	Σ	29b. Signature and title of	ertifier				29c. License	number			ned (Month, L	
	19				(		P >	ND	4560	50	11	126/6	غ -
	5		30. Name and address of pe	rson who	completed caus	e of dea	th (Item 23a) (Typ	Print) Dpino	ler Sin	isocie	M	D 20	91-
CH.	Sta Registra	te ar	31. Date filed (Month, Day	0 5	2005 32. 5	gistrar's	Signature	park					

			1 - For State Registrar		Maryland / Do	epartm Certific	ent of H	ealth ar D <i>eath</i>	nd Menta	al Hygie		39058
п	Physici	ian	1. Decedent's Name (First, Middle	o, Last)	0 =	2 1 1				te of Death onth	Day Yea	3. Time of Death
	/Medi	cal	CARMEN  4a. Facility Name (If not institution	give street and number	BE		ih. Tourn or	Location of I		EMBER		
	Examir	ner	NORTH WEST	HUSPITAL	,,			LLSTOL	)		BALT	
	Funeral		5. Social Security Number	6. Sex 7	Age (In yrs. last birthe	fay) If Un	der 1 Year	If Under 24	Hrs. 8. Dat	te of Birth		lirthplace (State or Foreign Country)
	Director		213-14-5992	1□ M 203F	84 Yr	Mont s.	hs Days	Hours	Min. (Mo	onth, Day, Ye ril 13	,1921 Pe	nnsylvania
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town of	r Location						10d. Inside City Limits
	Mary Fied	ţō	MD Balt	imore	Windsor	Mi11						1 ☐ Yes Ş∰No
	or 28s	Funeral Director	10e. Street and Number			10f.	Zip Code			10g.	Citizen of What (	Country?
	ath wi	ral	8613 Inwood Ro	ad			21	244			USA	
	er de	nue	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S. s?	13. Was De If Yes, s	ecedent of His specify Cubar	spanic Origin n, Mexican, F	? (Specify Ye	s or No- etc.)	14. Race - An Black, W	nerican Indian,
36	irs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ed 1 Tes 2 I		1 🗆 Ye	s 2⊠ No	Specify:			Specify: W	_
ŏ	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or fleme 23a or 28a-1 show thit, the Medical Examiner must be positived at	ted	15. Decedent	's Education	16a. D	ecedent's U	Isual Occupa	tion		16b	. Kind of Busines	s/Industry
2	ithin 7	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4o		e. DO NO	work done d Tuse retired)	uring most of	f working			,
2	led w tygier her th		17 Fathada Nama (Fina Asidda)	3	N	urse	1				Medica	1
Maryland 21215-0036	ntal H	Be	17. Father's Name (First, Middle, I Edward Mi	,					Name (First,		den Sumame)	
Z	should nd Me mark mark	ဥ	19a. Informant's Name/Relationsh		19b. M	ailing Addr	ess (Street a		nna Edi		ty or Town, State,	Zio Codel
Z	and 2		Carmen D. Boyce						Windsor			244
ore,	of Head		20a. Method of Disposition		20b. Place of D	sposition (			Date		Location - City of	
Ĕ	Pege ant: If ury o		1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Metro C				2/5/200	)5 Ca	tonsvill	e, Maryland
Baltimore,	permil. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Heath and Mental Hygiene. Deperment of Heath and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f show ery injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Euneral Service I	Kall	2	Witzk 1630	and Address e Fune Edmond	ral Ho Ison Av	ome of venue;	Caton	sville, sville,	Inc. MD 21228
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caus only one cause on each	ed the death. Do not line.	enter the m	node of dying	, such as car	rdiac or respira	atory arrest,		Approximate Interval Between
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9 X	death certificate be executed e attending physicien and od for use as the burial-transit	Physician/Medical	IF FEMALE:	23c. If yes, outcom	e of pregnancy							
Вох	death a atter d for u	clar	23b. Was decedent pregnant in the past 12 mopths? 1 □ Yes 2 □ No	1☐Live birth		3 □Ectopic 5 □ Other	pregnancy (specify)				23d. Date of de Month	elivery Day Year
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ō	A 를 들	$\vdash$	27. Manner of Death	28a. Date of In (Month, D		e of	28c. Injury a Work?	4 □ Nursin	ng Home 5 28d. Des	Residence scribe how in	6 ☐Other (Spe	ecify)
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<u>S</u> i≥	tal or Attendli s efter death. ef Director: A ed in by the fu	Certification:	3 Suicide 6 Could no 4 Homicide determin	286. Place of It	njury - At home, farm,	street, fact	ory, office		28f. Loca	ation (Street or Town, Sta	and Number or R	ural Route Number,
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	To the Hospital of within 24 hours of To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the bes xaminer: On the basis and manner s	of examination and/oi	investigati	od at the time on, in my opii	, date and pl nion, death o	ace, and due occurred at the	to the cause time, date a	(s) and marmer a ind place, and du	s state u. e to the cause(s)
	vithin To the	Z.	29b. Signature and little of centrier	7 73		2	29c. License i	number		29d. D	Date signed (Mon	th, Day, Year)
					$M \cdot D$		DSTT	22				
	1.		30. Name and address of person w	no completed cause of	death (Item 23a) (Typ	e, Print)	Noi	2411	WEST	HOSPI-	CEMBER	3 2005
	4		LEONARD RICHAR	DSON M.D.	5401 0420	OUR T	ROAD /	ZANDAC	LSTOW)	V M	0 2113	3
	Sta Registra		31. Date filed (Month, Day, Year) DEC 0 5 20	A5 Regist	trar's Signature	and a						
	ricgisti	-11	DEC 0 9 40	A STATE OF THE STA	, No Page							

State of Maryland / Department of Health and Mental Hygien 1 1 5 39059 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EDWARD M. BROWN, JR. 11 18 2005 12:38 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Mercy Medical Center Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Days Hours 1 M 2 □ F 214 56 1774 54 Director 1951 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location r than "naturel", or iteme 23s or 28s-f show the Medical Examiner: wat be notified at 10d. Inside City Limits Directo 1 Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1028 North Calvert St. 21202 death Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. American filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 3 Widowed 4 Divorced Specify: 1971 Year or Dates: Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Water Technician U.S. Government Ith and Mental Hygie 27 Is marked other intraumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be Edward M. Brown, SR. Virginia May Lennox 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 is Department of Health ar Important: If Item 27 is any injury or other trau Linda Brown - wife 1028 N. Calvert St. Baltimore, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cem | 11/23/05 Crownsville, MD 22. Name and Address of Facility G. J. Gonce Funeral Home, 21. Signature of Fugeral Service Licens 169 Riviera Dr. Pasadena, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** CORONARY ARTERY DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a sonsaquer se of) certificate be executed use as the burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 1 Live birth 3 Ectopic pregnancy ō 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Day Year ed by the e 5 Other (specify) 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Wunknown Deed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed? certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 XER/Outpatien 3 □ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 Natural death. filled in by the fi investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a
To the Funeral C
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0051891 November 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sam Hsu, MD St. 301 Paul P1. Baltimore, MD 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 2005 Registrar

			State of Maryland / Department of Health and Mental Hygiene 55 39060
			1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death
_	Physici		Stanley Richard Bolewski December 1 2005 0900 M
	/Media Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	1	* *	The Memori cal Hospital Caston (albot)  5. Social Security Number 6. Sex 7. Age (Infyrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		5. Social Security Number 220-36-8181  6. Sex 1 M 2 F  7. Age (Inflyrs. last birthday) 6. Sex 1 M 2 F  6. Sex 6. Sex 1 M 2 F  6. Sex 7 Age (Inflyrs. last birthday) 6. Sex 7 Age (Inflyrs. last birthday) 6. Sex 7 Age (Inflyrs. last birthday) 6. Sex 9. Birthplace (State or Foreign (Month, Day, Year)) 7. Age (Inflyrs. last birthday) 6. Sex 9. Birthplace (State or Foreign (Month, Day, Year)) 7. Age (Inflyrs. last birthday) 6. Sex 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  6. Sex 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  6. Sex 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  6. Sex 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  7. Age (Inflyrs. last birthday) 1 M 2 F  8. Date of Birth (Month. Day, Year) 1 M 2 F  8. Date of Birth (Month. Day, Year) 1 M 2 F  8. Date of Birth (Month. Day, Year) 1 M 2 F  8. Date of Birth (Month. Day, Ye
	74- A		Usual Residence of Decedent
2	arylan	-	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  MD Corolline Donton
5	the Mi	ecto	MD Caroline Denton 10f. Zip Code 10g. Citizen of What Country?
3	with I	급	11118 Branch Court 21629 U.S.A.
SLEWSK	death	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)
Q	36 after or its	y Fu	1 □ Never Married 2 M Marned 1 □ Yes 2 No If Yes, Give 1 □ Yes 2 No Specify: Specif
0	1215-0036 within 72 hours after death with the Maryland ene. then "naturel", or iteme 23a or 28a-f show then Maryleid Engineer investible mattified at	ed by	15 Decedent's Education 16a Decedent's Usual Occupation 16b Kind of Business/Industry
0:	oin 72	Completed	(Specify only highest grade completed)  [Give kind of work done during most of working life. DO NDT use retired)  [Give kind of work done during most of working life. DO NDT use retired)  [Navistar]
1	C = =	Com	12 Material Handler Truck Parts
	be filed tall Hyg	Be	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
111	should be nd Mental marked	2	John Bolewski  Sophie Demboski  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
17	Mand 2 si ealth an 27 is:		Patricia Bolewski / Wife 11118 Branch Court, Denton, MD 21629
3	other		20a. Method of Disposition 20b. Place of Disposition (Name of Disposition - City or Town, State
STANLEY	Baltimore, Maryland 2 permit. Pages 1 and 2 should be filed Department of health and Mental Hyd important: If item 27 is marked other eny injury or other traumatic event, ance.		1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Glen Haven Mem Pk 12/05/05 Glen Burnie, MD
5	Balt permit. Depent Import eny inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, P.R.
	m gorad		23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate
			shock, or hearf failure. List only one cause on each line.  Interval Between Onset and Death Onset and Death
	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)  a. METASTATIC PANCREATIC CANCER 7 months  Due to (or as a consequence of):
	Examiner		
	D :	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying
	and I-trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last  Due to (or as a consequence of);
	68760, ilicate be executed g physicien and as the burial-transit	alE	
	I Records, P.O. Box 68760, The law requires that the death certificate be executed tate has been signed by the attending physicien and tage 2 should be deteched for use as the burial-transit	ledical	
	Box 6 eath certif	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy
	O. E	Physician/M	1   Yes 2   No 9   Unknown 9   Unknown 9   Unknown
	P. (hat the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
	Cords, P.O.  **requires that the de been signed by the should be detached	d by	1 Yes 2 No 3 Probably 4 Minknown
	aw real	Completed	24a. Was an autopsy findings available prior to completion of cause of
	Vital Rec sicion: The law contilicate has t	Com	performed? death?  1 Yes 2 No 1 Yes 2 No
	/ita	Be	25. Was case referred to medical examiner? Hospital: 26. Place of Death (Check only one)
1	Physic this cral dir	To	1 No 1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)
	Division of Vital Records, P.O. tor Attending Physician: The law requires that the datler death.  Director: After this certificate has been signed by the fin by the funeral director, page 2 should be detached.	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury 28b. Time of Injury Work? 1 Year 1 Yes 2 No 28d. Describe how injury occurred 28d. Describe how injury occurred
	ViSI	tifica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, larm, street, factory, office City or Town, State)
	Differ of rate Differ in led in		
	Hosp 24 hou Fune Kely fi	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	Division of Vital To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Med	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)
	1 6		► COLEMBER 1, 2005
	10		30. Name applications of person who completed cause of death (Item 23a) (Type, Print)
	.3		STEPHEN RUALD, M.D MEMOKIAL HOSPITAL AT EAS TON  31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Sta Regist		30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)  STEPHEN RUALD, M.D MEMORIAL HOSPITAL AT EASTON  31. Date filed (Month, Day, Year)  DEC 0 5 2005

	1. State Amend Item:	State of I s# 2 per PH	Maryland / Y & 20c	Department of PCE reflected	of Health and 1997 1997 1997 1997 1997 1997 1997 199		, in grant in	39061			
Physician	1. Decedent's Name (First, Middle	e, Last)				2. Date of D	eath 11-28-05	3. Time of Death			
/Medical	MARY A	LICE BANK	S			Novemb	e <del>r 29 200</del>	5 2247 M			
Examiner	4a. Facility Name (If not institution	n, give street and number	er)	4b. City, To	wn, or Location of De	ath	4c. County of D	eath			
	HARFORD MEMO				DE GRACE	rc   0 0		ORD CO			
Funeral	5. Social Security Number	6. Sex 7. 1 ☐ M 2 ☐ F	Age (In yrs. last bi		Pays Hours Mi	n. (Month, D	rth ay, Year)	Birthplace (State or Foreign Country)			
Director	219-12-8258 Usual Residence of Decedent		92	110.		FEB.	17 1913	MARYLAND			
iand	10a. State 10b. County		10c. City, Tov	m or Location				10d. Inside City Limits			
1215-0036 within 72 hours after death with the Maryland ene. Then "natural", or itame 23a or 28a-f ahow the Madical Examinar rount for notified at property of the Madical Examinar rount for notified at property of the Madical Examinar rount for notified at property of the Madical Examinar rount for notified at property of the Madical Examinar rount for the Madical Examinar round for the Madical Examinar rount for the Madical Examinar rount for the Madical Examinar round for the Madical Exami	MARYLAND H	ARFORD CO		BELAIR				1 ☐ Yes 2/3/No			
vith the Mar or 28s-f all by notified	10e. Street and Number	ARPORD CO		10f. Zip Co	ode		10g. Citizen of What	Country?			
3a or		מת מוזכ			21015		II C A	·			
diter death virtues 23 intercent	400 THOMAS 1	12. Was Decede		13. Was Deceden	t of Hispanic Origin?	(Specify Yes or N		merican Indian,			
Fur Italy	1 Never Mamed 2 Mar	ied Armed Force			Cuban, Mexican, Pue	erto Rican, etc.)	Black, W	hite, etc.			
036 urs a	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:	1 ☐ Yes XI	No Specify:		Specify:	BLACK			
21215-0( ed within 72 hot ygjene. ser than "neture it, the Wedgal E.	15. Deceder	t's Education st grade completed)	16a	Decedent's Usual C	Occupation done during most of w	porkina	16b. Kind of Busine	ss/Industry			
21.2 Phh 7. Phh 7. Phh 7. Phh 9. Phh	Elementary/Secondary (0-12)	College (1-40	or 5+)	life. DO NOT use i	retired)	Orking					
12 by Barting	6th grade			HOMEMAKER			N/A				
DG file		Last)			18. Mother's N	ame (First, Middle	, Maiden Surname)				
is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiens.  If the 27 is marked other than "natural", or itame 23a or 28a-f show other treumatic event, the Marical Examinar mount for indiffied at TO Be Completed by Funeral Director					IDA I	MURPHY					
2 sho	19a. Informant's Name/Relations	hip (Type, Print)	191	o. Mailing Address (S	treet and Number or i	Rural Route Numb	er, City or Town, State	e, Zip Code)			
y Wand 2 mand 2	Lois Hunt/Dau	ghter	4	00 Thomas	Run Rd.,	Belair, 1	Md., 21015				
or Heart rest	20a. Method of Disposition 1XXBurial 2 ☐ Cremation	2 Domouni from Sta	ramata	of Disposition (Name ory, crematory or other		Date	20c. Location · City Churchvil	or Town, State			
Pege Pege Int: If	'4 □Donation 5 □Other (5			RY CEMETER	RY 12	-03-05	WHITE MAR	SH, MARYLAND			
Baltimore,	21. Signature of Funeral Service	M	'n	22. Name and A WM C BRO	Address of Facility WN COMMUN	ITY FUNE	RAL HOME-H	ARFORD, P.A.			
10310		Deoleur			IILADELPHI	A BLVD, A	ABERDEEN, I	MD 21001			
1	23a. Pant. Enter the disease, or shock, or heart failure. List	only one cause on each	sed the death. Do n line.	not enter the mode o	f dying, such as cardi	ac or respiratory a	arrest,	Approximate Interval Between Onset and Death			
Physician	Immediate Cause (Final disease or condition	Right	Middel	4 x Lo	Wer Lobe	Preur	mrie	5 days			
/Medical Examiner	resulting in death)  Due to (or as a consequence of):										
Q Examine	Sequentially list conditions,	b									
	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a cons quence	of):							
0, \\ \triangle \text{executed} \\ \text{en and riei-transit} \\ \text{Examiner} \end{array}	that initiated events resulting in death) Last	c		-0			··				
68760,  icate be executed physicien and is the buriel-transit edical Examin	rosoning in dodair, East	Due to (or	as a consequence	or):							
8760, icate be exphysicien is the burie		d									
A Se entitive of Me entitive of Me		22a Muna autoor	no of organisms								
Box eth car witendir or use	23b. Was decedent pregnant in the past 12 months?		2 Fetal death				23d. Date of of Month	delivery Day Year			
S, P.O. Box (so that the deeth certificated by the ettending be detected for use by Physician/M.	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟Pregnant 9⊟Unknowr	t at time of death	5 ☐ Other (special	y)			,			
P. O	Part II. Other significant condition	ons contributing to death	h but not resulting i	n the underlying caus	e given in Part I	23a Did i	tohacco use contribute	to the cause of death?			
Sample Records, vital Records, sician: The law requires the certificate has been signe rector, page 2 should be decompleted by	Cerebra		emia	. The distance of the				Probably 4 Donknown			
CAN Polynomial Record The law requires the has been signated as should	11 +		No to the last of								
Fec law law be 2 s law	Hyperle	nsin				24a. Was	an 24b. Were prior t	autopsy findings available to completion of cause of ?			
Con The Page	/ /						ormed2 death 2 ☑ No 1 ☐ Y	es 2 No			
/ita	25. Was case referred to medica examiner?					eath (Check only	one)	TIONAL CARE			
To hysik of the life of the li	1 ☐ Yes 2 ☐ 10		atient 2 ER/O				dence 6 (S)	pecify) UNIT			
ng P After t Anera	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of In (Month, I	njury 28b. Day Year)		Injury at Work?	28d. Describe	how injury occurred				
Vision Attending r death. ector: After by the fune	2 ☐ Accident investi	gation		М	1 Yes 2 No						
Division of Vital Records is after death.  Division of Vital Records is after death.  The law requires after this certificate has been signed in by the funeral director, page 2 should be Certification; To Be Completed by	3 ☐ Suicide 6 ☐ Could 4 ☐ Hornicide determ	200. Place of	Injury - At home, fa etc. (Specify)	arm, street, factory, of	fice	28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,			
C Italia											
Division of Vital Records, P.O. Box 6  To the Hospital or Attending Physician: The law requires that the deeth certific within 24 hours after deeth ship services to the Funeral Director: Alier this certificate has been signed by the eltending p completely filled in by the funeral director, page 2 should be deteched for use as Medical Certification; To Be Completed by Physician/Medical Certification; To Be Completed by Physician Ph	29a. Certifier 1 Certifyir (Check only 2 Medical one)	ng Physician: To the be Examiner: On the basis and manner	s of examination ar	e, death occurred at to door investigation, in	he time, date and place my opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)			
thin thin on the mple	29b. Signature and title of certifie		stated.	29c. Li	cense number		29d. Date signed (Mo	onth. Day. Year)			
F.3 F.8	1/0		$\bigcirc$			11					
	30. Name and address of person	eg, M.		<u> </u>	-15 99	7	11-29-	נע			
4	30. Name and address of person	wno completed cause o	r death (Item 23a)	(Type, Print)	and and	in Un		C 0 0 0 =			
	31 Date filed (Month Day Year)	32 Pari	strar's Signature	447 31	UNIDO A	VE. MIX	VICE DE	02/4 6			
State Registrar	31. Date filed (Month, Day, Year)	2005	in the	Special			IVE_	0, -1018			

Booker Thomas CULBERTSON
Baltimore, Maryland 21215-0036

À.	
Box 68760,	
P.O. B	
Records,	
of Vital	
Division	

		Please *	Type or Print in I	Black Indelible Ink	. Ensure All	Copies Are	Legible.	
		For	State of Marylar	nd / Department of I		ental Hygiene	105	39062
		1 - State Registrar		Certificate of	Death	Reg. No		
Physici	an	1. Decedent's Name (First, Middle, Last	1)	1		2. Date of Death December	y / a Year	3. Time of Death 2:40 A M
/Medic	al	1000KEK	street and number)	CULE	r Location of Death		. County of Deat	
Examin	er	4a. Facility Name (If not institution, give	. 11	4b. City, Town, (	A HA		PRINCE G	~
Funeral		DOCTOR'S COMMO 5. Social Security Number 6. Se	x 7. Age (In yrs.	Jast birthday) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Birt	hplace (State or Foreign
Director		215-16-1770 15	XM 2□F 8	Yrs. Months Days	Hours Min.	AUG 21,19	924 19.	ARILAND
p >		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ity, Town or Location				10d. Inside City Limits
show	5			,	0-1			1 ☐ Yes 2 No
the A	Director	MARYLAND PRINCE GE 10e. Street and Number	OKGES CO.	101. Zip Code	REL	/ 10g. Cit	tizen of What Co	unto?
rs after death with the Maryland f, or iteme 23s or 28s-f show zamost must be matified at		12011 BDA	OKMUI (	21101	2070	8	115	A,
	Funerai	11. Maritaf Status	12. Was Decedent Ever in U	J.S. 13. Was Decedent of I If Yes, specify Cub	lispanic Origin? (Spe	cify Yes or No-	14. Race - Ame	
hours after tural', or ite	Fu	1 Never Married 2 Married	1 DYes 2 No ff Yes, Give		an, mexican, Puerto i Specify:	rican, etc.)	Black, White	e, etc.
2 3 2 4	d by	3 NWidowed 4 □ Divorced	Year or Dates: FEB.	5,1946			Specify 152	ACK
nati	Completed	15. Decedent's Edi (Specify only highest grad	ucation de co <i>mpleted)</i>	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of workil	16b. K	ind of Business/	findustry
filed within Hygiene. other then "	d m	Elementary/Secondary (0-12)	College (1-4or 5+)	WELL	_	50	ARROW.	1 PAULT
Hyginer ant,		17. Father's Name (First, Middle, Last)		W Contract		(First, Middle, Maiden		SIOINI
should be filed within and Mental Hygiene. marked other then imatic event, lite M	To Be	MELIVIN	Ca	LBERTON	E117	A	416	GET
s 1 and 2 should be filed within 72 h Health and Mental Hygiene. Item 27 is marked other then "natu other traumatic event, the Naulcal	_	19a. Informant's Name/Relationship (T		19b. Mailing Address (Street	and Number or Rura	l Route Number, City o	or Town, State, 2	Zip Code)
and 2 alth a	j.,	RONALD GENTI	RIJ (SON)	5 SOFT WI	UTER C			MO. 21117
permit. Pages 1 and 2 Department of Health importent: if item 27 i any injury or other tre		20a. Method of Disposition  1   Surial 2 □ Cremation 3 □ I	/	Place of Disposition (Name of cemetery, crematory or other pla	ce)	ate 20c. Lo	ocation - City or	Town, Slate
Pages ment of I tent: if it	١,	4 □ Donation 5 □ Other (Specify,	(G)	ARRISON FOR	EST 12-	9-05 Ou	INGSP	ILLS MD.
permit. Departminemporte		21. Signature of Funeral Service Licens	600	22. Name and Addre	ss of Facility B	ROWNJK	2. FUNE	RAL HOME
2 705 e d		repect)	N. William	XITUN	, rullon	MYC, NI	ALTO, M	12011011
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.	Was				Approximate Interval Between Onset and Death
Pnysician /Medical:		Immediate Cause (Final disease or condition resulting in death)		NGESTIVE HE	EART F	AILURE		
Examiner			Due to (or as a consec	quence of):				
	ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec	quence of):				
executed executed on and rial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.					
be executed icien and burial-transit		resulting in death) Last	Due to (or as a consec	quence of):				
ate be hysici	Physician/Medical	•	d					
deeth certificate b attending physic	Med	IF FEMALE:						
eth ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1☐Live birth 2☐Fet	af death 3 Ectopic pregnanc	у		23d. Date of deli Month	ivery Day Year
the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□ Pregnant at tīme of e 9□ Unknown	death 5 Other (specify)				,
uires that the de i signed by the a id be detached f		Part fl. Other significant conditions co	ontributing to death but not re-	sulting in the underlying cause gi	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
uires n sign Id be	d by	ANASA	ARCA			1 ☐ Yes 2	□No 3□Pr	obably 4 Nhknown
w require been si should b	ete		NEGESTIVE	SEPSIS		24a. Was an	24b. Were au	itopsy findings available
he la e has age 2	Completed	CELLU		02/0/0		autopsy performed?	death?	topsy findings available completion of cause of
Attending Physician: The laver deforation of Attending Physician: The laver deforation of Attending Attending Description of Attending Description of Attending Description of Attending Description of Attending Description	0	25. Was case referred to medical	21120		26. Place of Death	(Check only one)	Tores	2 No
nysici Ils cer direc	ToB	examiner? 1 ☐ Yes 2 No	Hospital: 1X Inpatient 2	ER/Outpatient 3□ DOA Ct	NAC .	ne 5 ☐ Residence	6 ☐Other (Spe	cify)
Terth neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury Wo	ry at 2	28d. Describe how injure	ry occurred	
eath. or: A	catic	2 Accident investigation		M 1	Yes 2 □ No			
or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of fnjury - At h building, etc. (Speci	nome, farm, street, factory, office ify)		28f. Location (Street ar City or Town, State		ıral Route Number,
To the Hospital or Attending Physician: The law requires that the deeth certificate be within 24 hours after dearth.  To the Funeral Director: After this certificate has been signed by the attending physicie completely filled in by the funeral director, page 2 should be detached for use as the burn		no outilis Monte in the						
Hos 24 ho Fun stely 1	edicai	29a. Certifier ertifying Phy (Cneck only one) 2 Medical Exam	iner: On the basis of examination and manner stated.	owledge, death occurred at the fi ation and/or investigation, in my	me, date and place, a opinion, death occurre	and due to the cause(s ad at the time, date and	) and manner as d place, and due	to the cause(s)
To the Hospital within 24 hours a To the Funeral is completely filled	Med	29b_Signature and title of certifier	and marrier states.	29c. Licen:	se number	29d. Da	te signed (Monti	h, Day, Year)
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210				m 23a) (Type, Print)		110		
) 1		30. Name and address of person who of DR. MARTIN WEL- 31. Date filed (Month, Day, Year) DEC 0 5	TZ 7525 GRA	EENWAY CT. DR	GREENBE	LT MARVE	AND 2	0770
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature & A		7		
Regist	ar	חבר ה פ	2003	No. Therese				

		•	1- For Amend Item 26 per verb., G850, 12/05/05dbb Certificate of Death	d Mental Hygie	005 39063
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day Year 3. Time of Death
	/Medic	al	Larry Carey  Ab. City, Town, or Location of D	Death (	4c. County of Death
1	LXdIIII	iei	Bayview Medical Center Baltin	nore	
	Funeral Director	0	12-58-6859 154 20F 52 Yrs. Months Days Hours N	Hrs. 8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)  Mary Ian  D
	yland 10W		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	8a-f sl	Director	MD Baltimore		12Yes 2 No
	with the	Dire	10e. Street and Number 10f. Zip Code 2/2 Code	10g.	Citizen of What Country?
	ems 2:	Funerai	11. Marital Status  12. Was Decedent Ever in U.S Armed Forces?  13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	irs afte	by Fu	1  Never Married 2  Married 1		Specify: Plack
2-00	within 72 hours after death with the Maryland ene. than "naturel", or items 23a or 28a-f show the Medical Examinar must be notified at		15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	working 16b	b. Kind of Business/Industry
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Evantal or must be notified at	Completed	Elementary/Segondary (0-12) College (1-4or 5+)		1 mtrak,
	buld be filed within Mental Hygiene.  arkad othar than atic event, Italy	Be C		Name (First, Middle, Maid	ten Sumame)
Maryland	should bind Ment	2	19a. Informant's Name/Relationship (Type, P 19b. Mailing Address (Street and Number o.	SICO COC	property State Zin Code)
Ma	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I a Monce.		Ti FFa 111 S. Careel Denebber 1218 Edison +	tighway.	But 10 21200
ore,	jes 1 a of Hei if item or othe	1	20a. Method of Disposition  20b. Place of Disposition (Name of cametery, crematory or other place)	Date do	. Location - City or Town, State
Baltimor	permit. Pages Department of i Important: If it any injury or o		*4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee  \$21 Name and Address of Funeral Service Licensee	12-1-05 B	2 Hinory MD
Ba	permit. Departr Imports any inju		150 Clata MOI363 Upp 2100 k	La Both	MD 21212
			shock, or heart failure. List only one cause on each line.	diac or respiratory arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	4 3	resulting in death)	or dosie	Cristian Board
	Examiner		Due to (or as a consequence of):  Sequentially list conditions  D.		
	slt slt	iner	Sequentially list conditions, if any, leading to immediate cause. Enarly depring Cause (Disease or injury		
Ċ,	execut n and ial-tran	Examine	that initiated events c. Pue to (or as a consequence of):		
8760	cate be executed physician and the burial-transit	dicai	d.		
9	death certific ettending p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of delivery
Box	The law requires that the death certificate has been signed by the ettending Islange? Should be detached for use as	Physician/Me	in the past 12 months?  1  Yes 2 No  1  Yes 2 No		Month Day Year
P.0	that the de ned by the e detached f	Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to the cause of death?
rds,	quires that n signed I uld be det	d by		1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	ne law requir has been s ge 2 should	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of death?
al R				performed 1 ☐ Yes 2 🔀	7 death? No 1 ☐ Yes 2 ☐ No
Vital	S S 1	o Be	examiner?	Death (Check only one)  ig Home ————————————————————————————————————	e 6 ☐Other (Specify)
n of	ng fter	on: T	27. Manner of Death  1 Manual 5 Pending (Month, Day Year)  28a. Date of Injury 8b. Time of 28c. Injury at Work?	28d. Describe how in	
Division	Attending in death. ector: After by the fune	ficati	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office		t and Number or Rural Route Number,
Div	s efter s ofter al Dire	Certification:	4 Homicide Getermined building, etc. (Specify)	City or Town, Si	ate)
	To the Hospital or Attending Ph within 24 hours efter death. To the Funeral Director: After th completely filled in by the funeral	Medicai	29a. Certifier (Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death of and an analysis of examination and/or investigation, in my opinion, death of an analysis of examination and/or investigation, in my opinion, death of the control of		
	ro the within 2 го the	Mec	29b. Signature and title of certifier 29c. Liceose number	/	Date signed (Month, Day, Year)
)			► X1. (100 D384	-03 /	1/29/05
			30. Name and and person who completed cause of death (Item 23a) (Type, Print)  Howard Steiner (For A Wen	dy Dubi	n) Raven Blvd
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1 su	الما الما الما الما
	Registr	ar	DEC 0 5 2000 page 1		

			1 - For State Registrar		epartment of Health and Certificate of Death		nns 3916L
£	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     Charles M Clark     As. Facility Name (If not institution, give street)	at and number)	4b. City, Town, or Location of Dea	2. Date of Death Month De	ay Year 3. Time of Death  2 2005 10:454,
	Funeral Director		Baltimore Washingto  5. Social Security Number  214-22-9807  Usuat Residence of Decedent	n Medical Cente	Glen Burnie  Gly   Glen Burnie   Glen Burnie	A. Date of Birth	Anne Arunde1  9. Birthplace (State or Foreign Country)
	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or items 23a or 28s-f show event, the Medical Examinar must be notified at	Funeral Director	MD Anne Arund 10e. Street and Number 101 Aquahart Rd	el Glen Bu			10d. Inside City Limits 1 □ Yes 2√√No itizen of What Country? USA
5-0036	2 hours after d latural, or iten	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education	Amped Forces?  ☐ Yes 2 ☐ No f Yes, Give fear or Dates:	If Yes, specify Cuban, Mexican, Puel  1 ☐ Yes XX No Specify:  Pecedent's Usual Occupation	to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White  Kind of Business/Industry
2121	0 = 0 5	Be Completed		mpleted) (i	Give kind of work done during most of worde. DD NOT use retired)  Sman  18. Mother's Na	me (First, Middle, Maider	Printing
, Maryland	s 1 and 2 should be if Heelth and Mental Itam 27 is marked o other traumatic eve	To	19a. Informant's Name/Relationship (Type, F Elizabeth Clark	Wife 10	Ida Rey Mailing Address (Street and Number or R L Aquahart Rd, Gler	ural Route Number, City	
Baltimore,	permit. Pages 1 Department of H Importent: If Ital any injury or ott		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)  21. Signard of Funeral Service License	vai iroin otate	nedral Cemetery 12 22. Name and Address of Facility Fink Funeral Home,	-6-05 Ba	ocation - City or Town, State
₹8.	Physician /Medical Examiner	ər	23a. Part Enter the disease or complication shool or heart failing list only one call immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	MO1148  Institute caused the death. Do not use on each line.  Due to or as a consequence of the consequence	426 Crain III. SW, enter the mode of dying, such as cardia	Glen Burnie cor respiratory arrest.	, MD 21061 proximate Interval Between Onset and Death
æ	icate be executed physician and s the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence of)	to think.		
O. Box 6	death certif e attending d for use a	Physician/Med	in the past 12 months?	yes, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
ecords, P	w requires that the de been signed by the should be detached t	þ	Part II. Other significant conditions contribu	ting to death but not resulting in the	ne underlying cause given in Part I.	1 ☐ Yes 2	use contribute to the cause of death?  No 3 Probably 4 Unknown
r	ilcien: The la certificate has rector, page 2	Be Completed	25. Was case referred to medical examiner?	alt		24a. Was an autopsy performed?  1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
	g je je	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	ia. Uate of Injury (Month, Day Year)  2Bb. Tim Inju	e of 28c. Injury at Work?  M 1 Yes 2 No	lome 5 Residence 28d. Describe how injur	ry occurred
S	To the Hospitel or Attending it within 24 hours after deeth. To the Funerel Director: After completely filled in by the funer.	Medical Certif	4 Homicide determined 20  29a. Certifier (Check only 2 Medical Exeminer: 0	on the basis of examination and/o	street, factory, office eath occurred at the time, date and place r investigation, in my opinion, death occu	City or Town, State	
	vithin 2  To the comple	Med	29b. Signature and title of certifier	ma maniel stated.	29c. License number ) 4-3977		te signed (Month, Day, Year)
	Sta Registr		30 Name and elidre's of berson who comple	led cause of death (Item 23a) (Ty		ine in	2/06/

			1 - State Amend Item# 18	State of Maryland / D per FH G850 11/	epartment of Health a	and Mental Hygi	ene g. No. 005 39065
	Dhusisi		Decedent's Name (First, Middle, Last)			2. Date of Death Month	
	Physici /Medio		Judith M. De	Foor		Decembe	r3, 2005 10:50A M
	Examir	er	4a. Facility Name (If not institution, give st		4b. City, Town, or Location of		4c. County of Death
			2 Glyndale Co		Reistersto		Baltimore
	Funeral Director		213-42-4630	7. Age (In yrs. last birth	rs. Months Days Hours	24 Hrs. 8. Date of Birth (Month, Day, July 13	9. Birthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	Manyl f eho	ō	MD Baltimo		sterstown		1 ☐ Yes <b>X</b> [X]No
	the 128	rect	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	3a of	Funeral Director	2 Glyndale Co	urt	21136		U.S.A.
	death	Jera		Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Original If Yes, specify Cuban, Mexican	gin? (Specify Yes or No-	14. Race - American Indian,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. by other than "natural; or Iteme 23a or 28e-1 show event. It a Madical Exprinter man be realised	by	1 Never Married XXMarried 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:	1 ☐ Yes X2 No Specify:	, Puerto Hican, etc.)	Black, White, etc.  Specify: White
5-0	72 ho	Completed	15. Decedent's Educ	ation 16a. I	Decedent's Usual Occupation (Give kind of work done during most	of working	6b. Kind of Business/Industry
21		npie	Elementary/Secondary (0·12)	College (1-4or 5+)	life DO NOT use retired) Director of	or working	
21	filed wi Hygien other th	Co		4	MedicalRecord		Health Care
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event.	Be	17. Father's Name (First, Middle, Last)		18. Mothe	r's Name (First, Middle, M. Dan	aiden Sumame) <b>Z</b>
χ	should be ind Mental I	ျ	Roland Myers			orothea <del>Var</del>	
Jar	s 1 and 2 should f Health and Mer Item 27 is marke other treumatic	1	19a. Informant's Name/Relationship (Typ	9, <i>Print)</i> 196.	Mailing Address (Street and Number		
	s 1 and 3 if Health item 27 other tre		William DeFoor  20a. Method of Disposition	20b. Place of	Disposition (Name of	-	Cstown, MD 21136 Oc. Location - City or Town, State
altimore,	Pages nent of I int: If it		1 ☐ Burial 2 Cremation 3 ☐ Re	moval from State cemetery	v, crematory or other place)		· ·
Ē	permit. Pag Depertment Important: I eny injury o		4 □ Donation 5 □ Other (Specify)  21. Signature → Finer   ervice Lice	Metro	Crematory Inc.		uneral Chapel P.A.
Ba	permit. Pages Depertment of Important: If i eny injury or ance.		21. Signature of America Cities				vings Mills, MD2111
			23a. Part1. Enter the disease, or complic	ations that caused the death. Do n			
	Physician /Medical Examiner	X COLUMN	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of	c colou	CA	In al Between
68760,	icate be executed physicien and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of			
Box 68	ath certif	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ ₩6	c. If yes, outcome of pregnancy  1 Live birth 2 Fetel death 4 Pregnant at time of death		23d. Date of delivery Month Day Year	
P.0	that the de led by the e deteched t	hys	9 Unknown	9□ Unknown			
	juires that n signed t	ρ	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
Records,	The law requi	Completed				24a. Was an autopsy	prior to completion of cause of
व	ilcien: Th certificete rector, pag	ပို	25. Was case referred to medical				INO 1 Yes 2 SHO
Vital	ysicien: is certific director,	00	examiner?	spital:		of Death Check on one rsing Home 52 Residen	
ō	g Physical this neral direction	٦: T	27. Mano f of Death	28a. Date of Injury 28b. Ti	ime of 28c. Injury at	28d. Describe how	
9	th. Afte	ig l	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) In	jury Work? M 1 ☐ Yes 2 ☐ i	No	
Division	i or Attending efter death. Director: After I in by the fune	Certification:	3 Suicide 6 Could not be determined	28f. Location (Stre City or Town,	net and Number or Rural Route Number, State)		
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	cian: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and	d place, and due to the cau th occurred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	To the within To the compl	Me	29b. Signature and title of certifie	uter MD	29c. License number $0.353$	~ ~	d. Date signed (Month, Day, Year)
	/	1	30. Name and address of person who cor	npleted cause of death (Item 23a) (	-		
_	2		Flavio Kruter md	555 South Cont	erStreet Westr	niuster, MD	21157
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature			
	Regist	-	DEC 0 5 2005	Reven de la	realed		
DH	HMH 17 Rev 1/2	001		9			

**ORIGINAL** 

			For State Registrar	State of	Marylan		artment <i>tificate</i>			and M	lental Hyg	giene	5	39066
			1. Decedent's Name (First, Mid			22-					2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		EDWA	FD E	DWA	KUS					NOVEMBE		005	21:30M
	Examin		4a. Facility Name (If not instituti	on, give street and num	ber)		4b. City, T	Fown, or	Location of	of Death		4c. County	of Death	
			Johns Hopkins	Buynews	relical (	cuter	50	71+	mo	re		N	/A	
	Funeral		5. Social Security Number		. Age (In yrs. I		If Under 1	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Dey	Year)	9. Birth	place (State or Foreign
	Director		219-16-6961	1 <u>√</u> M 2□F	80	Yrs.	WIGHTIS	Days	110013		July 1	4,1925	Per	nnsylvania
	g ,		Usual Residence of Decedent	<b>.</b> .	10a Cib	y, Town or Lo	antina							40d Incide City Limits
	aryle of a	_	10a. State 10b. Coun	•	Toc. City	y, Town or Lo	cation		Dı	unda	1 レ			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	8a-1	cto	Maryland	Baltimore					D(	unaa				
	or 2	Funeral Director	10e. Street and Number				10f. Zip (	Code				10g. Citizen of		•
	8th w	ā	7522 Cypres	· · · · · · · · · · · · · · · · · · ·						224				States
	e de de	nu nu	11. Marital Status	12. Was Deced	es? WW	S. 13. \	Was Decede f Yes, spect	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Spo 1, Puerto	ecify Yes or No- Rican, etc.)	14. Rad Bla	e - Ameri ck, White,	can Indian, . etc.
36	s eff	by F	1 ☐ Never Married 2€ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	Voro	an	1 ☐ Yes 2	<b>⊠</b> No	Specify:			Specif	V: 1.7L	
21215-0036	72 hours efter deeth with the Marylend Insture!, or iteme 23s or 28s-1 ehow dical Examinar must be notified at	D D		ent's Education	(es:		ient's Usual	. One	tion			16b. Kind of B		nite
7	27 c	Completed		nest grade completed)		(Give	kind of work DO NOT use	k done d	uring most	t of work	ing	100. Kind of B	usiness/in	idustry
12	within ene. then "	Ĕ	Elementary/Secondary (0-12)	College (1-	4or 5+)							Stee	1 Tnc	dustry
	Hygie Hygie offi-	ပို	G.E.D.  17. Father's Name (First, Middle	e. Last)		CI	ane O			r's Name	(First, Middle,			AUBCL y
Maryland	e d is S	Be		ranklin Edv	zarde	Sr					ice M. (		-/	
Ξ	should and Men marke umatic	၉	19a. Informant's Name/Relation		varus,		a Address	(Street a			I Route Number		State 7in	Code
Ma	ith en 27 ie r traur		Mrs. Barbara		(Wife)	1	2 Cyp				altimore	-		21224
	ges 1 and t of Heeith if item 27 or other tr		20a. Method of Disposition	II. Edwards								20c. Location -		own State
ŏ	Pages nent of H int: if its		1 ☐ Burial 2 ☐ Cremation		(ALO	lace of Dispo emetery, cren							•	
Ë	tmentant		'4 □Donation 5 □Other		Oak	Lawn			1	3/20				, Maryland
Baltimore,	permit. Pages Depertment of Important: if if eny infury or o		21. Signeturi of Funeral Service	e Licensee	20	22					Home of			Inc. 21222
			23a. Pert1. Enter the disease, shock, or heart failure. Li	or complications that ca st only one cause on ea	used the deeth ch line.	. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Lu		ance	_							Onset and Death
7	/Medical		resulting in death)	a. Due to (o	r as a consequ		-							
	Examiner		Sequentially list conditions b. Previous											
	_	ē	Sequentially list conditions, if any, leading to immediate cause Er ter Underlying Cause (Disease or injury	Due to (o	r es a consequ	ence of):								
V	icate be executed physicien end s the burial-transit	Examiner	that initiated events	G									10	
ó	exe en er rial-t	EX	resulting in death) Last	Due to (o	r as a consequ	uence of):								
8760,	ysici	cal		d									148	
9	tifica ng ph es th	Je d								- 0				
Вох	thet the deeth certific led by the attending p deteched for use es	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnath 2 Fetal		Ectopic pre	000000				23d. Da	e of delive	ery
	deetl e atte	S	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregna	nt at time of de		Other (spe					Mo	nth	Day Year
P.0	by the eched	hys	9 🗆 Unknown	9□ Unknov	vn									
	The law requires thet the deeth certificate be executed ate hes been signed by the attending physicien end page 2 should be deteched for use as the burial-transit	by P	Part II. Other significant condi	tions contributing to dea	ith but not resu	alting in the ur	nderlying ca	use give	n in Part I.		23e. Did tol	bacco use cont	ribute to ti	he cause of death?
Ę	quire n sig uid b	De la									1 🗆 Ye	es 2 🗆 No	3 Prob	ably 4 Unknown
Records,	w requir s been s should	Completed									24a. Was a	n 24b.	Vere auto	psy findings available
Re	he lav e hes	Ĕ								_	autops	me¢l?   c	leath?	mpletion of cause of
Vital	ding Physicien: The i h. After this certificate he funeral director, page	Ö	25. Was case referred to medic	val					26 Place	of Death	(Check only on		Yes	ZINO
>	Physicien: rthis certificaral director, j	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 4	patient 2 🗆 I	ER/Outpatien	3 DOA	Othe			ne 5 ☐ Reside		er (Specif	iv)
of o	Phy graid		27. Manner of Death	28a. Date of		28b. Time of		c. Injury Work			28d. Describe ho			97
o	ding P. After	ţ	1 Natural 5 Pend 2 Accident inves	fing (Month)	, Day Year)	Injury	м		? es 2 🔲 N	No				
Division	i or Attending efter deeth. Director: Afte i in by the fune	Certification;	3 ☐ Suicide 6 ☐ Coul	d not be 28e. Place of	f Injury - At ho	me, farm, stre	et, factory,	office		1			er or Rura	I Route Number,
5	efter Dire	ert	4  Homicide	building	g, etc. (Specify	")					City or Towr	n, State)		
	ours ours neral		29a. Certifier 4P Certify	ring Physician: To the b	est of my know	wledge, death	occurred a	t the time	e, date and	d place, a	and due to the ca	ause(s) and ma	nner as si	tated.
	To the Hospital or Attentwithin 24 hours effer deet To the Funeral Director: completely filled in by the	Medical		al Exeminer: On the bas	is of examinat									
	o thing of thing of thing of thing of the contract of the cont	E e	29b. Signature and title of certif				29c.	Licens <i>e</i>	number		2	9d. Date signed	(Month,	Dey, Year)
<b>\</b>	⊢ 3 ⊢ ŏ		11/1/1				18	00	- 0	727		-1-		76 - 7
•	14		m will	MEDIC	AL DO	CTOK	Drint'	~ < >	- 00		1	oveunt	285	47,2005
	りつ		30. Name and address of person	- +1 11	or death (item	ZJa) (Type, I	-rint)	,10	111	110-11	O Ecoteru	Ana		
			31. Date filed (Month, Day, Yea	WIN JOHNS HU	gistrar's Signat	ture =	Mean	ul (	intel	1 4 14	u rustem	AVE		
	Sta Registr		DE G	0 5 2005	Salar Golgital	M. A		and the same						
	riegisti	u,			200	* 1	9							

			For State Registrar	State of N	Maryland	_	artment of H rtificate of I		lental Hygie: <sub>Reg.</sub> (	6002	39067				
	1/2		1. Decedent's Name (First, Middle, La	st)					2. Date of Death Month	Day Year	3. Time of Death				
	Physicia /Medic		Mary Francis Ear	1у					11/30/200	5	11:30 P <sup>M</sup>				
	Examin	-	4a. Fecility Name (If not institution, giv	e street and numbe	er)		4b. City, Town, or	Location of Death		4c. County of Dea					
**			Anne Arundel Med				Annapoli			nne Arur					
128.3	Funeral Director		5. Social Security Number 6. S 483-16-6025	Sex 7 1□M 2∏F	Age (In yrs. ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 01/12/1932 9. Birthplace (State or Foreig Country) I owa						
	P .		Usual Residence of Decedent		10a Cib	. Town or Lo	ti				10d. Inside City Limits				
	arylar show	_	10a. State 10b. County		Toc. City	, TOWITOI LO	cation				1 XYes 2 No				
	8a-f	ecto	Maryland Anne Aru	ınde1	Croi	Eton	101 71 0-1-		100	Citizen of What C					
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show appringuy or other traumatic event, the Medicul Exert or must be rediffed at ance.	Funeral Director	10e. Street and Number 1676 Carlyle Dri	ve Apt. H	I		10f. Zip Code 21114		USA		ountry:				
	dea ems	ner	11. Marital Status	12. Was Decede Armed Force	is?	5. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh					
36	rs after	by Fu	1 ☐ Never Married 2√ Married 3 ☐ Widowed 4 ☐ Divorced	1 Tes 27 If Yes, Give Year or Date			1 ☐ Yes 2 <b>/</b> CXNo	Specify:		Specify:	nite				
21215-0036	2 hou	ed	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	ation		. Kind of Busines					
215	nin 72	Completed	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed)  Coltege (1-4d)	or 5+)	(Give life.	kind of work done of DO NOT use retired	during most of work. d)	ing						
212	d with	E	Liomorkary/occordary (5 12)	3		Libra	rian		I	Public					
פ	e file al Hy othe	Be	17. Father's Name (First, Middle, Last	1)				18. Mother's Name	e (First, Middle, Mai	den Sumame)					
<u> a</u>	Menta	To	Wiley Mills					Netty Red							
Maryland	2 sho and is my		19a. Informant's Name/Relationship				,		al Route Number, Ci						
2	and lealth m 27 har tr		Charles T. Early/	Husband	Janh Bi			_	. H Croft	Location - City o					
altimore,	ages 1 nt of H : If Ite		20a. Method of Disposition 1 ☐ Burial 2XX remation 3 ☐		rrea		osition (Name of matory or other place	12/03	1000	aldorf, N					
Ħ	artmen artmen ortant injury E.		4 □ Donation 5 □ Other (Speci 21. Signature of Funeral Service Lice		Hu		ematory  2. Name and Addre		ert E. Eva						
Ba	21. Signature of Funeral Service Libertsee 22. Name and Address of Facility Robert E. Eva										5				
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death disease or condition  a. Bruncho alveolar Lung cancer 1,5 years												
	Physician		Immediate Cause (Final disease or condition	Bron	cho a	(veo)	ar Lun	a canci	er		1,5 years				
	/Medical Examiner		resulting in death)		as a consequ		ŧ								
	Zammer		Sequentially list conditions,	b											
	pe tis	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequ	иепсе от):									
	and and al-tran	хап	that initiated events resulting in death) Last	c	as a consequ	uence of):									
8760,	cate be executed physicien and the burial-transit	dical Examiner	· ·	S d											
687	ficate physis the	edic		Q											
Box	requires that the death certific een signed by the attending p hould be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 19 months? 1  Yes 2 1 10 9 Unknown		n 2 ∏ Fetal tat time of de	death 3	□Ectopic pregnancy □ Other (specify) _	y		23d. Date of d Month	alivery Day Year				
s, P.O.	res that tigned by	by Ph	Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the u	ınderlying cause gıv	en in Part I.			to the cause of death?				
ord	w require been sig should b	ted							Yes	2 No 3 I	Probably 4 Unknown				
Vital Records,	aw 2 sb	Completed							24a. Was an autopsy performer	prior to	autopsy findings available completion of cause of				
al F	That are	1 Yes 2 No 1 Yes 2 No													
V.		Be	25. Was case referred to medical examiner?	Hospital:		FD/0	Ott	100	h (Check only one)	о Понь /о.					
of	Physical distribution	5.	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inp	Injury	ER/Outpatie 28b. Time of			ome 5 Residence 28d. Describe how		<del>ө</del> сігу)				
on	Attanding r death. ector: After by the fune	tior	Natural 5 Pending 2 Accident investigation		Day Year)	Injury		rk?  Yes 2 No							
Division of	Attar r dea ector by the	ifica	3 Suicide 6 Could not determined	d 286. Place of	Injury - At ho	me, larm, st	reet, factory, office		281. Location (Stree City or Town, S		Rural Route Number,				
Ö	s afte	Certification:	4   Homicide	building	, etc. (Specify	"			Only or 10 mm, c						
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier Certifying P (Check only one)	Physician: To the beaminer: On the basi and manner	is of examina	wledge, dea tion and/or in	th occurred at the til rvestigation, in my o	me, date and place, opinion, death occur	and due to the caus red at the time, date	e(s) and manner and place, and do	as stated. ue to the cause(s)				
	To the Mithin To the compl	Me	29b. Signature and title of certifier			-	29c. Licens	se number	29d.	Date signed (Mor	nth, Day, Year)				
	. >- 0		* Rance as	eine.	MO		D52	830	De	cemberi	12005				
8	7		30. Name and address of person who	o completed cause	of death (Item	23a) (Type	Print)	Anacoli							
6	St	ate	31. Date filed (Month, Day, Year)	32.	ristrar's Signa	iture		111101-11	i, mo						
1.5	Regist		DEC 0 5 2	UUD	Ester 1	U. A	oset.								

Certificate of Death

Reg. No.

30

Yee

USA

Month

1 Tyes

29d. Date signed (Month, Day, Year)

December 1, 2005

Dav

XXNo

White

2005

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2X No

Maryland

2:01 P M

2. Date of Death

November

Month

For Stete Registrar

**Physician** 

1. Decedent's Name (First, Middle, Last)

Mildred Marie Fulton

DHMH 17 Rev 1/2001

within 24 hours a To tha Funaral I

10

29a. Certifier

(Check only one)

31. Date filed, (Month)

29b. Signature and title of certifie

Neil A.

Day, Year 5 / []

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Meade

Medical

State Registrar 32. Registrar's Signatur

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9811 Mallard Drive, Laurel, MD 20708

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner states.

29c. License number

D14220

Della Mae Fellers Unpend item#2a, Print in Black Indelible Ink. Ensure All Copies Are Legible. 05-7959 State of Maryland / Department of Health and Mental Hygiene AKG Reg. No. 005 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 25, 2005 **Physician** 5:38 P Della Mae Fellers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours 1 □ M 2 🛣 F Yrs. Aug. 6, 1944 Tennessee 216-88-3614 61 Director Usual Residence of Deceden 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County worle I ir than "naturet", or ttems 23a or 28a-f ehor the Medical Examinar must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 407 Morningside Drive 21061 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 Never Married 20 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) filed within Hygiene. other then Elementary/Secondary (0-12) College (1-4or 5+) Ø Homemaker Own Home other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 te marked oth eny lighty or other traumatic event 9DBs. Be Savannah Blanche Vaughn Aron Thomas Bennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill D. Fellers/Husband 407 Morningside Drive, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk 12/1/2005 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee, 313 Talbott Avenue, Laurel, MD M00773 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ladure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive atherosclerotic cardiovascular Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine hed by the attending physicien end deteched for use es the burial-transit The law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No 3 Ectopic pregnancy Day Year Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic obstructive pulmonary disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ pinknown been si Completed 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 Ness 2 □ No has certificete 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠Yes 2 No 1x1npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 14 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 Yes 2 No investigation М 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician; within 24 hours after death.
To the Funeral Director: After this certifice completely filled in by the funeral director.

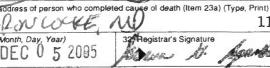
State Registrar

- GARON CO 31. Date liled (Month, Day, Year)
DEC 0 5 5 2005

29b. Signature and title of certifier

4 Homicide

29a. Certifier



MI

111 Penn Street, Baltimore, Maryland

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

November 29, 2005

Medical

			for State Registrar	State of Marylar		tment of lificate of		Mental Hy	/gienı Reg. Ne	11115	39070
	Physici	an	Decedent's Name (First, Middle, La			.,		2. Date of D Month	Da		3. Time of Death
	/Medic Examin		Katherine Wood Ga  4a. Facility Name (If not institution, given		4	lb. City, Town,	or Location of Deat	Decemb		2005 County of Death	8:35 p M
	Funeral Director		500-28-5801	Hospital Sex 7. Age (In yrs.	last birthday)	Clinton If Under 1 Year Months Days	If Under 24 Hrs		irth ay, Year,	ince Geo	orge's hplace (State or Foreign unity) ginia
	Maryland f ehow	or	Usual Residence of Decedent  10a. State 10b. County		ty, Town or Loca	tion					10d. Inside City Limits 1 ☐ Yes 2 X No
	th the I	irect	Maryland Prince G	eorge's Sul	tland	10f. Zip Code			10g. Ci	itizen of What Co	untry?
	ath wi	ral	3202 Ryan Drive	1		20746				ed State	
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "naturel; or Items 23a or 28e-f show eumatic event, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ②∏ No If Yes, Give Year or Dates:		s Decedent of es, specify Cub	Hispanic Origin? (Span, Mexican, Puerl Specify:	pecify Yes or N to Rican, etc.)	0-	14. Race - Ame Black, White Specify: B1:	
21215-0036	within 72 ho ne. han "natur na Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give kir. life. DC	NOT use retire	during most of wo	rking	Uni	(ind of Business/l	Industry
nd	tal Hygid d other event, I	To Be Co	12 17. Father's Name (First, Middle, Last Richard Wood	)	Houseke	eeper	18. Mother's Nar			Virginia Sumame)	1
lary			19a. Informant's Name/Relationship				t and Number or Ru	ıral Route Numt			lip Code)
	s 1 end of Heelth Item 27 other tr		Diane Carey ( 20a. Method of Disposition	Daughter)	Place of Dispositi	ion (Name of	, Suitlan	nd, MD 2		ocation - City or	Town State
Ē	Pages nent of int: If It iny or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State Pi	cemetery, cremat edmont I	tory or other pla Baptist	Those O	, 2005		cey Mill	
Baltimore,	permit. Pages Department of Important: If It eny injury or o		21. Signature Funeral Service Lice		urch Cen J.H 108	lame and Address Bell	ess of Facility Funeral t., NW, C	Home, I	nc.		22903
	Physician /Medical Examiner		23a. Part1. Enter the difea e r con shock, or heart filure List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the dear one cause on each line.  a. SEIZU (2)  Due to (or as a consec	th. Do not enter	the mode of dy	ing, such as cardiad	c or respiratory a	arrest,		Approximate Interval Between Onset and Death
	ate be executed hysician and the burial-transit	Icai Examiner	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect of the conse	ENquence of):	CEP	HALOPA	YHTZ			
.O. Box 6	the death certifica y the ettending ph ached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 Live birth 2 Feta 4 Pregnant at time of o	al death 3 ⊟Ed	ctopic pregnanc ther (specify) _	sy			23d. Date of deliment	very Day Year
rds, P	v requires that the de been signed by the i should be detached	b	Part II. Other significant conditions	contributing to death but not res	sulting in the unde	erlying cause gr	ven in Part I.		_	_	the cause of death?
al Records,	The lav	Completed						24a. Was auto perfi 1 Yes	psy ormed?	prior to c death?	topsy findings available ompletion of cause of 2 No
<u> </u>	siclan certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🛪 No	Hospital: 1 X Inpatient 2	ISD/O	a⊂ pot   Dt	26. Place of Dea	- N	-21		
Division of Vital	ding P	ation; To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	4   Nursing F	28d. Describe		6  ☐Other (Spec ry occurred	nfy)
DIVIS	i 전투 6	Certification:	3 Suicide 6 Could not be determined		ome, farm, street fy)	t, factory, office		28f. Location ( City or To	Street ar wn, State	nd Number or Rui e)	ral Route Number,
	Fur Fur stely	edicai	29a. Certifier 1X Certifying P  (Check only 2 Medical Exa- one)	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death or ation and/or inves	ccurred at the ti stigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s date an	) and manner as d place, and due	stated. to the cause(s)
	To the Hos within 24 h To the Fun completely	Me	29b. Signalure and title of certifier	. 0		29c. Licen:	se number		29d. Da	te signed (Month	, Day, Year)
	N		1/20000	Louis		D	48158		DEC	21, 20	200
3	1		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type, Pri		580 OX	NH UN	. 1	n 107	41
	Sta Registr		31. Date filed (Month, Par Year) 5	32 Registrarie Sign		anti)			- ,	- 0	1.3

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			Ce	rtificat	e of L	Death	7		Reg. No	UU	7	11000
П			1. Decedent's Name (First, Middle, Las						2. Date of D	eath			3. Time of Death		
	Physicia		Margaret 1	E. Goette							Month Novemb	Da Der		Year 2005	11:34A <sup>M</sup>
	/Medic		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location	of Death				y of Death	
	Examin	er	Laurel Regional				T.s	urel				_ E	rin	ae Go	orge's
			5. Social Security Number 6. S		(In vrs. la	st birthday)				r 24 Hrs.	8. Date of 8	irth			
	Funeral Director			□ M 2⊠F	91		Months	Days	Hours	Min.	(Month, D Nov • 9	av. Year)	17.7	New	lace (Stete or Foreign try)
	Director		Usual Residence of Decedent						1	1	1100.	, 10	111	IVCVV	LOIK
	land		10a. State 10b. County		10c. City,	Town or Lo	cation							1	0d. Inside City Limits
	feh ed	ō	MD Prince	George's	T.a	urel									1 ☐ Yes 2 🔀 No
	10 the 1	Director	10e. Street and Number	dedige b		ur cr	10f. Zip	Code				10n Ci	tizen of	What Cour	trv?
	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f ehow he Medical Examinar must be notified at	ā	8618 Kiama Road				701. 24		2070	0					,
	s 23	Funerai		12. Was Decedent E	var in II S	12	Was Dass				oitu Vac as N			USA ce - Americ	an Indian
	er de	ŭ	11. Marital Status	Armed Forces?		. 13.	If Yes, spec	cify Cuba	n, Mexica	in, Puerto F	cify Yes or N Rican, etc.)	٥-		ck, White,	
2	s aft	by F	1 ☐ Never Married 2 ☐ Married  3XXWidowed 4 ☐ Divorced	1 ☐ Yes 2 N If Yes, Give Year or Dates:	0		1 ☐ Yes	2CXNo	Specify	<i>r</i> :			Specif	v Whi	te
3	hour lural		15. Decedent's Ed		1	16a. Dece	dont's Heur	al Occup	ation			165 K	Cincle of D	usinoss/Inc	funtar
0500-617	"na "na	Completed	(Specify only highest gra	de completed)		(Give	kind of wo	rk done d	durina mo	st of workin	g	100. 1	b. Kind of Business/Industry		
V	withir ne. han	E D	Elementary/Secondary (0-12)	College (1-4or 5-	+)		memak		,				,	Or II.	
Z	filed Hygie other I		17. Father's Name (First, Middle, Last)	y y		110	шешах	er	18 Moth	nor's Nama	(First, Middle	a Maidar		Own Ho	ome
and	be for	Be											Jumai	110)	
Š	2 should be filed within 72 hours after death with the Marylan and Menth Hygiene is and Menth Hygiene is marked to the Hygiene is marked to the Hygiene is marked to the Multical Examinating the rollified at eumetic event, the Multical Examinating the rollified at	7	Edward Gormley								Courtn				
Mar	2 sh and Is m		19a. Informant's Name/Relationship (								Route Numi	-			Code)
III.	s 1 and 2 should f Health and Men item 27 is marke other treumetic		Marjorie Rabicko	w/Daugntei					venu		urel,		2070		
9	of Hea of Hea if item		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □	20b. Pla	ace of Dispo metery, crea	natory or o	ne of other plac	е)	Da	ate	20c. L	- City or To	wn, State		
Ē	Pag ment ant: I		`4 □Donation 5 □ Other (Specify	MD	Natio	nal M	iem.	PK		/2005		rel			
Baitimor	permit. Pages 'Department of H Important: If Ite any injury or ot		21 Signature of Funeral Service Licen				2. Name ar			,					ne, P.A.
מ	88 = 8		h mino (A)	MOOK M	01103		313 T	albo	tt A	venue	, Laur	el,	MD	2070	7
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	of cations that caused	the death.	Do not en	er the mod	le of dyin	g, such a:	s cardiac or	respiratory :	arrest,			Approximate Interval Between
	Physician		Immediate Cause (Final	Cerebi										İ	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a			OSIS								minutes
	Examiner			•			monia								days
li.		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Aspiration Pneumonia  Due to (or as a consequence of):											uays	
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury												
_	xecu and	ха	that initiated events c.  resulting in death) Last Due to (or as a consequence of):												
2	be e	aiE	l												
68/60,	eath certificate be executed attending physician and for use as the burial-transit	edicai	•	d											
X	ding se as	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnan	icv							224 D	ate of delive	
o n	death of atten		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3	Ectopic p	regnancy							Day Year
o.	res that the death signed by the atter be detached for u	Physicia	1 ☐ Yes 2 ☐XNo 9 ☐ Unknown	4☐ Pregnant at i 9☐ Unknown	time or de	aui 5	Other (sp	еспу)							
7.	hat the d by Jetac		Part II. Other significent conditions of	ontributing to death bu	it not resul	ting in the u	nderhing c	ausa anv	an in Part	1	23e Did	tobacco	use con	tribute to th	e cause of death?
Ś	requires that been signed b hould be deta	by				ing in the d	ilderly alg c	au se givi	DIT HET I CALL	1.		Yes 2			abty 4 🖾 Unknown
coras	w require been signature	Completed	Acute_Re	enal Failur	re						'-	105 2	140	3 1 100	ably 4 (2) DIKHOWIT
ပ္	> 40	pie					24a. Wa	DDSV	24b.	Were autoprior to con	osy findings available				
r	The lav	)OII						pert	ormed? 2 X No	,	death? 1 ☐ Yes				
VITal	ician: Th certificate rector, pag	a	25. Was case referred to medical						26. Plac	e of Death	(Check only				
	S (2)	o B	examiner? 1 □ Yes 2 X No	Hospital: 1 X Inpatier	nt 2 🗆 E	R/Outpatie	nt 3 🗆 DC	Oth	er: 4 □ N	lursing Hom	ne 5 Res	sidence	6 🗆 Oti	ner (Specify	<i>'</i> )
O		on: T	27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time o	f 2	28c. Injun Work	at	2	8d. Describe	how inju	iry occui	red	
0	th. : After	at lo	1 Anatural 5 Pending 2 Accident investigation		160)	Injury	М		Yes 2	]No					
<u> S</u>	Attending or death. rector: After by the fune	fica	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Rot Charles Care Could not be determined 28e. Place of Injury - At home, farm, street, factory, office										l Route Number,		
DIVISION	in Dig	Certificat	4 Homicide building, etc. (Specify)  City or Town, State)												
	Hospital 24 hours a Funerel [		29a. Certifier 1 Certifying Ph	ysicien: To the best o	of my know	rledge, deat	h occurred	at the tin	ne, date a	ind place, a	nd due to the	cause(s	) and m	anner as st	ated.
	Hospital     24 hours     Funerel letely filled	Medical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examinati	on and/or in	vestigation	, in my o	pinion, de	ath occurre	d at the time	, date an	d place,	and due to	the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	11.1			296	c. License	e number			29d. Da	ite signe	ed (Month,	Day, Year)
	F 3 F 8		> /A/Allina	T 11121	ul	- Vu	1	1)	139	16		LIAN	1	4. 30	2005
	1		" W Welland	, 0000	anth //	000) 7	7 7	0	56	10		VUY			دسم
	D .		30. Name and address of person who										_		

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

		1	For State Registrar	State o	f Marylan		artment of H rtificate of L		nd Ment	al Hygie,	CHHA	390	72	
•	Dhusiai		Decedent's Name (First, Middle, Last)				Mont				h Day Year			
	Physicia /Medic	al -	Connie Lee Grasser							December 1, 2005 7:00 A M			0 A M	
	Examin	er	4a. Facility Name (If not institution, give street and number) 8975 Rosewood Way				4b. City, Town, or Location of Death			4c. County of Death  Howard				
2	<u> </u>		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	Jessi If Under 1 Year	_	4 Hrs. 8. D.	ate of Birth	a	Birthplace (State	or Foreian	
	Funeral Director		218-46-6036	1 ☐ M 2 ☐XF	58	Yrs.	Months Days	Hours	Min. (A	Month, Day, Ye.	ar)	Country) ennessee		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, it a Madical Exameter must be twitted at once.	Director	Usual Residence of Decedent		40-00	~						10d. Inside C	Sia . I i a ia	
			10a. State 10b. County 10c. City, Town or Location Jessup								1 □ Yes 2 XNo			
į			Maryland Howard  10e. Street and Number			10f. Zip Code			100	Citizen of What	Country?			
4		0	8975 Rosewood Way				20794				United States			
		Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?			S. 13.	Was Decedent of Hispanic Origin? (Specify Yes or No. 1f Yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. Race - American Indian, Black, White, etc.			
9			1 □ Never Married 2 □ Married 1 □ Yes 2 🗷 No If Yes, Give Year or Dates:			1 ☐ Yes 2 ☒ No Specify:				1, O(C.)	vnite, etc.			
903		d by									Specify: White			
5-		lete	(Specify only highest grade completed) (Giv			(Give	edent's Usual Occupation e kind of work done during most of working DO NOT use retired)				16b. Kind of Business/Industry			
21215-0036		Completed	Flementary/Secondary (0-12) College (1-40r 5+)				Sales Manager				Sunny Surplus Stores			
br.		BeC	17. Father's Name (First, Middle,	Last)				_	's Name (Firs	st, Middle, Maid	den Sumame)			
Maryland		To	Albert Anders	5										
Jan			19a. Informant's Name/Relations Mr. Kevin Gras	sser			ng Address (Street a					e, <i>Zip Code)</i> 20794		
6		1	20a. Method of Disposition	(son			Rosewood	a way	Date	ıp, Mar		or Town, State		
altimore,	ages nt of h		1 ☐ Burial 2 ☐ Cremation	3 Removal from	State	emetery, crei	natory or other plac	1 -	12/6/20			River, N	(ID	
Itin	ortani ortani injury		4 □ Donation 5 ☑ Other (S		ment Ho	lly Hi	11 Mem. G Name and Address	ans.						
Ba	Dep per lmp yne		22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222								ĺ			
	Physician // Medical Examiner purish transit	d	22a-Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between											
F			Immediate Cause (Final disease or condition		Metastatic Breast Cancer							Onset and		
100			resulting in death)	a	Due to (or as a consequence of):									
			Sequentially list conditions	b										
u/		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	Due to (or as a consequence of):									
4		хап	that initiated events resulting in death) Last	c. Due to	c									
8760,														
687	ifficate g phys as the	edic		J							1			
Вох	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy								23d. Date of delivery			
			in the past 12 months? 1 Yes 2 No	4□Pregr				Other (specify)			Month Day Ye		Year	
P.O		Phy	9 Unknown							23e. Did tobacco use contribute to the cause of death?				
ds,		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							1 Yes 2 No 3 Probably 4 Unknown				
Oro		etec							_	24a. Was an		a outaney findings	available	
Vital Records,		Completed								autopsy performed	? deat		cause of	
B		e Co	25. Was case referred to medica					26 Place		Yes 2	No 1□'	Yes 2□No		
5		0 8	25. Was case referred to medical examiner?  1  Yes 2 70 Other: 4 Nursing Hot							me 5 Pasidence 6 □Other (Specify)				
		n: T	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred							,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
io		atio	1 🖾 Natural 5 🗀 Pendir 2 🗀 Accident investi	gation				M 1 Yes 2 No						
Division		Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	of Injury - At home, farm, street, factory, office 28f. Location (Street, etc. (Specify) City or Town, S					et and Number or Rural Route Number, State)					
Ω		S												
		edicai	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the Within 2 To the Complet	Me	29b. Signature and title of certifie	r	,		29c. Licens	e number		29d.	Date signed (M	Ionth, Day, Year)		
	- 5 - 0		) my		- · · h	$\mathcal{Q}$ .	2	453	90	De	ecemb	er1,2	2,00,5	
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)											
			myo MIN(M.D.) 4114 Jula augma reva # 208, 500 1100000, 1100 21236											
State Registrar														

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Ma	aryland /		artment o			d Mental H	lygiene Reg. No	000	39073	
	Physicia		1. Decedent's Name (First, Middle, I	.ast)		GAL	AND	5		2. Date of Month,	Death 28	<sup>y</sup> 200	3. Time of Death	
12.3	/Medic Examin		4a. Facility Name (If not institution, g VN(VERSITY OF MARY	ive street and number) (LAND MEOTCA	L CENT	TER	4b. City, Tov BALT	Ma	RE	eath	40	. County of D	Death	
	Funeral Director		180-54-3555		(In yrs. last )	birthday) Yrs.	If Under 1 Y Months D		Jnder 24 F ours A	Ain. 8. Date of (Month). June 1.	Birth Day, Year L <b>,</b> 196(	9.	Birthplace (State or Foreign Country) Pennsylvania	_
	Maryland f ehow		Usual Residence of Decedent  10a. State  10b. County  Maryland  Anne Aru	nde1	10c. City, To Linthi		ecation						10d. Inside City Limits 1 ☐ Yes 2 🂢 No	
	or 28a-	Funeral Director	10e. Street and Number				10f. Zip Co				10g. Ci	tizen of Wha	t Country?	
	eath w	erail	443 Kingwood Road	12. Was Decedent I	Ever in U.S.	13	210		nic Origin'	(Specify Ves or	No.	USA 14 Bace - A	American Indian,	_
920	72 hours after death with the Maryland natural; or tlems 23a or 28a-f ehow itsal Exeminer must be notified at	ρ	1 Mover Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		1	If Yes, specify		exican, Pi	? (Specify Yes or uerto Rican, etc.)			Vhite, etc.	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene the Health and Mental Hygiene teams 23a or 28a-f show them 27 te marked other transfer than "natural" or item 27 te marked other transfer	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5		(Give	dent's Usual C kind of work of DO NOT use r	one durin	g most of	working		aurant	ess/Industry	
d 2	e filed Il Hygie other	Be Co	17. Father's Name (First, Middle, La	st)		GICI		18.	Mother's	Name (First, Mid				
ylar	should be nd Mental nmarked c	To E	Andrew Galanos							Wetzling				
Mar	and 2 sho ealth and n 27 le m		19a. Informant's Name/Relationship Heather M. Galanos	(Type, Print)						r Rural Route Nui <b>Evansvi</b> l			te, Zip Code)	
Baltimore,	ges 1 and of Heal		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State	ceme	tery, crei	sition (Name in natory or other	of r place)		Date	20c. L	ocation - City	or Town, State	
Ħ	Cometary, cramatory or other place)   Cometary, cramatory or other p									7/05	Lar	isdowne	Pennsylvania	-
Ba	Grusuma O Fillon 5305 Hartord Road Bal										arvlar	d 2121	4	1
i k	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia shock, or heart failure. List only one cause on each line.    Physician   Immediate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):										y arrest,		Approximate Interval Between Onset and Death	
jej	Examiner		Sequentially list conditions,	b. HYPE	2TEN	1511	2N						YEARS	
	and i-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequenc	e of):		_						ļ
8760,	icate be executed physician and s the burial-transit	Icai		d										_
.O. Box 6	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal dea		□Ectopic pregr □ Other (speci					23d. Date of Month	f delivery Day Year	
Δ.	quires that in signed b uld be deta	٥	Part II. Other significant conditions	s contributing to death b	ut not resultin	g in the u	nderlying caus	e given in	Part I.		id tobacco	_	te to the cause of death?  Probably 4 Unknown	
al Records,		Completed					itopsy erformed?	prior	e autopsy findings available r to completion of cause of th? Yes 2 \sumbox No					
Vital	25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Death  28. Date of Injury  28. Date of											Specify)		
ion of	ding h. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigat	iry occurred										
Division	± the of	Certification:	3 Suicide 6 Could no 4 Homicide determine			28f. Locatio City or	n (Street a Town, Stai	nd Number o	or Rural Route Number,					
	To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To the within 2 To the comple	×	29b. Signature and title of certifier	8_	MO		4	icense nu	× . C		1100	170	Nonth, Day, Year)	
-	5/		30. Name and address of person w	o impleted cause of d	eath (Item 23 th Gre	а) (Туре,	Print) Street	158 Bol	Timo.	c MD	, 212	01		
4	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 0 5	2005 32 Registr	ar's Signature		adil			c,MD				

Amend State of Maryland / Department of Health and Mental Hygiene Caso 12/03/05dhb Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** November 19, 2005 12:31 AMM Reba Gershman /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 5675 A Harpers Farm Road Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🛱 F Director 338-28-8745 71 June 15, 1934 Minnesota Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner rount be notified at 1 ☐ Yes 2 ☑ No Columbia Howard Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 5675 A Harpers Farm Road USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: white þ 3 ♥ Widowed 4 Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 a filed w. ... Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 occupational therapist health permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy important: if Nem 27 is marked other any injury or other traumath 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kenneth Edwin Wright Denise Irene Hygenberger ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2954 W. Eastwood Avenue Chicago, II Date 20c. Location - City or Town, State Sylvia Kete/sisiter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 ☑Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Funeral Service Licensee Ronald S. Wade Baltimore, MD 21201 Baltimore, MD 21201

23a. P. II. Enter the diseale, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line.

Acute Turbular Noorcogia Approximate Interval Between Onset and Death Acute Tubular Necrosis Immedia 4 Cause (Final disease or condition resulting in death) Physician ALUTE RENAC DAT NOW /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit be executed and Due to (or as a consequence of) P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 Yes 2 ₩No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this after death.
Director: After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ŏ within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ş 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) ္ 2 D51860 ho FISH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10700 CHARRA DRIVE #200 COUMBIO, MO 2/044 JUNATITAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Coside DEC 0 5 2005 Registrar

			Registrar	of Maryland / Dep Co	partment of Heartificate of	lealth and N Death	fental Hygie		39075
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Carol Ann Girzait	is			2. Date of Death Month December	Day Year 1 2005	3. Time of Death 12:10a M
	Examin		4a. Facility Name (If not institution, give street and no Klein Hospice		Liberty			4c. County of Death Frederi	
	Funeral Director		5. Social Security Number 342−52−6100 6. Sex 1 M 2√7 F  Usual Residence of Decedent	7. Age (In yrs. last birthda 48 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye Aug 10 19	9. Birth Cou 957 IL	place (State or Foreign Intry)
	Maryland f show	or	10a. State 10b. County Md Carroll	10c. City, Town or E1c	Location dersburg				10d. Inside City Limits 1 ☐ Yes 2√☐ No
	with the Page or 28a-	Funeral Director	10e. Street and Number 5902 Brighton Drive		10f. Zip Code 21784		10g.	. Citizen of What Cou USA	
0000	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heeth and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examities trust he notified at once.	by Funera	Armed F	orces? 2F No veA	B. Was Decedent of H If Yes, specify Cubi  1  Yes 2 No	an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Whi	, etc.
20-017	within 72 hou ane. than "natura te Macical E	Completed	15. Decedent's Education (Specify only highest grade completed	16a. Dec (Giv	edent's Usual Occup ve kind of work done . DO NOT use retired istered nu	during most of work d)	ing	b. Kind of Business/Ir nealth car	
Jana Z	uld be filed v Aental Hygie rked other tic event, th	To Be Co	17. Father's Name (First, Middle, Last) Zenon Paul Girzaitis	1 - 13			e (First, Middle, Mai		
, mary	and 2 shousely and A no 1 strains		19a. Informant's Name/Relationship <i>(Type, Print)</i> Nancy Girzaitis (sister)	5902	Brighton	Dr., Elde		ity or Town, State, Zi Id 21784	p Code)
pairimore	Peges 1 ment of H tent: if iter		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Resurred	position (Name of rematory or other place ction Cem.	12-10	)-05 Ju	E. Location - City or T	
מפ	permit Deper impor eny in		21. Signature of Funeral Service Licensee Parge Harght Specific		.U. Box 1	95 Sykesv	ille, Md		Chape1
	Physician /Medical Examiner	J.		(or as a consequence of):	ances	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death  L2.mos
8/00,	certificate be executed nding physicien and use as the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.	(or as a consequence of):					
Ď	ertificate ing phy e as the	Medic	IF FEMALE:						
.O. Box	atte atter	Physician/Me	23b. Was decedent pregnant in the past 12 months?	nant at time of death 5	☐Ectopic pregnancy	·		23d. Date of delive Month	ery Day Year
coras, r	w requires thet the de been signed by the s should be deteched	ρ	Part II. Other significant conditions contributing to d	leath but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to t	
9	The ia ete has page 2	Completed					24a. Was an autopsy performed	prior to co	opsy findings available on pletion of cause of
SION OF VICE	× 50	ation: To Be		Inpatient 2 ER/Outpati of Injury oth, Day Year) 28b. Time Injury	of 28c. Injur	er: 4 🗆 Nursing Ho	me 5 ☐ Residence 28d. Describe how i		m Hospice
DIVISION	spitef or Attending Phous elter death. erei Director: After th	Certification:	4 Homicide build	e of Injury - At home, farm, s ing, etc. (Specify)			City or Town, S		
	To the Hospitel of within 24 hours el To the Funerel D completely filled in	Medicai	29a. Certifier (Check only one)  2	e best of my knowledge, de easis of examination and/or oner stated.	ath occurred at the tin investigation, in my o	pinion, death occur	ed at the time, date	and place, and due t	o the cause(s)
1	¥ 3 £ 8	)_	March	M	DC	106701	\	Date signed (Month,	5
	O Sta	ate	Giner J. Good	of death (Item 23a) (Typi	a, Print)	orge St, Pl	iggs 281	, Balturo	we NO 2128
	Registr		DEC 0 5 2009	Saff Sand Star			•		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day December 2, **Physician** ANNA MAE 5:17 a<sup>M</sup> 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3126 Gracefield Road Apt. 121 Silver Spring Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 2, 192 Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2₩ F 179-14-5205 84 Yrs. Pennsýlvania Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir items 23a or 28a-f show direr must be notified at 1 ☐ Yes 2 ☐ No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3126 Gracefield Road Apt. 121 20904 U.S.A. Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 220 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XX Married ō Baltimore, Maryland 21215-0036 1 Yes 2XNo þ Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) the Mo other than Elementary/Secondary (0-12) College (1-4or 5+) Grade 10 Clerk National Geographic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Yovich Rose Smargie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Rose Marie McLeod daughter 10464 Stansfiled Road Laurel, Maryland 20723 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o once. cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \*4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven 12/06/2005 | Silver Spring, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 313 Talbott Avenue Laurel, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Lung Cancer - Metastatic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or initial Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical esn IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Diabetes Mellitus 1 Xes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Coronary Artery Disease has e 2 autopsy page performed certificate Hypertension Division of Vital XXNo 1 ☐ Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes XXNo 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 XXatural 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Xertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) re, mo D 22840 December 2, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Hazel Tape Kaiser Permanente Cherry Hill Road Silver Spring, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 0 5 2005

			1 - For State Registrar	State	of Marylar		artment of h rtificate of				Reg. No.	)5	39077
	Physicia	an	1. Decedent's Name (First, Midd	le, Last)						2. Date of Dea Month	Day	Yeer	3. Time of Death
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	Examin	er	4a. Facility Name (If not institution Oak Crest Ca		imber)		Parkvi		or Death			ltim	
3/1	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt (Month, Da	h Vaarl	9. Birth	place (State or Foreign
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	pu 🖫		Usuel Residence of Decedent  10a. State 10b. County	,	10c Ci	ty, Town or Lo	ocation						10d. Inside City Limits
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00	the N 28a-	rect	10e. Street and Number	TINOTC			10f. Zip Code				10g. Citizen of		intry?
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_	ems 2	ner	11. Marital Status	Armed F		J.S. 13.	Was Decedent of I	Hispanic Or an, Mexica	rigin? (Sp in, Puerto	ecify Yes or No Rican, etc.)	14. Red Bla	e - Ameri ck, White,	ican Indian, , etc.
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9 8	within 72 hours ane. than "netural", to M. dical Exe	ed b	15. Decede	nt's Education		16a. Dece	dent's Usual Occu	pation			16b. Kind of B	usiness/Ir	ndustry
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L athume Maryland 21215-0036	es 1 and 2 should be of Health and Ment fitem 27 is marked r other traumatic e		19a. Informant's Name/Relation Richard Breach		4	19b. Maili 34	ng Address <i>(Stree</i> 00 Parkf	and Numb	peror <i>Run</i> Drive	a <i>l Route Numb</i> e Balti	more, N	State, Zi D 21	236
3 6	es 1 and of Health of Health fitem 27 r other tr	١	20a. Method of Disposition		20b.	Place of Dispo cemetery, cre	osition (Name of matory or other pla	ice)		Date	20c. Location	- City or T	own, State
3	Pages nent of I ant: If it		1 ⊠ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (	3 ⊟Removal from Specify)	n State		d Mem. P	1	12/5	5/05	Baltimo	re,	MD
Baltimore	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee	1		2. Name and Addr eonard J		Ba	altimore	Maryl	and ord R	21214
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	/Medical Examiner		resulting in death)	Due t	o (or as a conse								
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Š	he lav	Completed								auto	osy ormed? 2 No	prior to death?	
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		1	For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H			giene 2005	39078
			Decedent's Name (First, Middle, La	st)				2. Date of Dear	th	3. Time of Death
п	Physicia		Russell	O. Hok				Month Decembe	er 3, 2005	( /O DM
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town, or	Location of Death	Docomo	4c. County of D	
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11/5	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. I	Birthplace (State or Foreign Country)
	Director		481-10-8665	M 2□F	91 Yrs.	Working Days	110010	Dec 10,		Iowa
	p ,	-	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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	Ne M	Director	MD Balt:	more	Re	10f. Zip Code	vn	1 1	10g. Citizen of What	Country?
	with I								-	•
	eath	Funeral	5 Franklin Wa	1. Was Decedent I	Ever in U.S. 13.	21136 Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	U.S.A. 14. Race - A	merican Indian,
	ter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes, specify Cubai		Rican, etc.)	Black, W	
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Ò	72 hours after death with the Maryland naturel', or Items 23s. or 28s-1 show deat Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occupa	ation Juring most of work	ina	16b. Kind of Busine	
21	within 7 ene. then "	nple	Elementary/Secondary (0-12)	College (1-4or 5	life.	DO NOT use retired,	)			
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	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Luana S. Rarey  20a Method of Disposition	Daughte	20b. Place of Disp	osition (Name of			Maryland 20c. Location - City	
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ta		0	25. Was case referred to medical				26. Place of Dea			
<b>\</b>	Physician: this certificantal director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpatie	nt 3 DOA Othe	er: 4 🗌 Nursing Ho	ome 5 Resid	dence 6 Other (S	Specify)
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Division	or Affects fit is death	Certification:	4 Homicide determine		ury - At home, farm, s c. <i>(Specify)</i>	reet, factory, office		City or Tow		r Rural Route Number,
	pitel ours a eral [		29a. Certifier 1 Certifying P	hysician: To the best	of my knowledge dea	th occurred at the tin	ne date and place.	and due to the o	cause(s) and manne	r as stated.
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical		miner: On the basis o	f examination and/or it					
	To the vithin To the Somple	Me	29b. Signature and title of certifier		2	29c. Licensi	e number		29d. Date signed (M	lonth, Day, Year)
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	X		30. Name and address of person who			, Print)		,	1 .	
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		ate	31. Date filed (Month, Day, Year)	75	ar's Signature	Boorato D				
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			For State Registrar	State of Maryland / [		tment of F ificate of		d Mental Hy	/gien Reg. Ñ	GUUD	39079
	Physici		1. Decedent's Name (First, Middle, Last) Estelle Hounsh	e11	_			2. Date of D Month Novem	D	ay Year 29 2005	3. Time of Death 6:00a
	/Medic Examin		4a. Facility Name (If not institution, give so 201 Watersville Re	·	1	4b. City, Town, o			4	c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 228-52-5673	M 2 TF 7. Age (In yrs. last bir		If Under 1 Year Months Days	If Under 24 H Hours M	irs. 8. Date of Bi in. (Month, D	av. Yea.	r)   Co.	nplace (State or Foreign untry)
	e Maryland 8a-f show	Director	10a. State 10b. County 10d Carroll	10c. City, Tow Mt. Ai		ition					10d. Inside City Limits 1 ☐ Yes 2 No
	th with th	rai Dire	10e. Street and Number 201 Watersville Rd	. Apt. 2C		10f. Zip Code 21771			10g. C	Citizen of What Co A	untry?
960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, If a Modical Ever, if at most be nuffered at once.	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 to No If Yes, Give \( \Lambda\) Year or Dates:		as Decedent of H res, specify Cuba Yes 21 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or Nerto Rican, etc.)	0-	14. Race - Amer Black, White Specify: Wh	e, etc.
21215-0036	d within 72 hi giene. sr than "natu Ir e Madical	completed	15. Decedent's Educ (Specify only highest grade	ation 16a.  Completed)  College (1-4or 5+)	(Give kii life. DC	nt's Usual Occup nd of work done O NOT use retired ing ass	during most of v d)	vorking		Kind of Business/lealth ca:	•
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e, Mar	1 and 2 sho Health and tem 27 is ma		19a. Informant's Name/Relationship (Type Wilma Barefoot (da 20a. Method of Disposition	ughter) 50	06 Da	vid Ct.		iry, Md 2	2177		
Baltimore,	Pages ment of h tant; If ite		1)☐ Burial 2 ☐ Cremation 3 🕅 Re '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 20b. Place of cemeter Ewing	ry, crema Ceme	tory or other place tery	12-	Date -5-05	Jon	Location - City or 1 esville,	Va.
Ball	permit Depart Import any in		21. Signature of Funeral Service License  Page Haget	ferbert	P.0	. Box 19	95 Sykes	sville, N	ld 2	1 Home & 1784	Chapel
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	)en			iac or respiratory a	*	TYPE	Approximate Interval Between Onset and Death
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P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director; After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	c. If yes, outcome of pregnancy 1 \( \subseteq \text{Live birth}  2 \subseteq \text{Fetal death} \\ 4 \subseteq \text{Pregnant at time of death} \\ 9 \subseteq \text{Unknown}		ctopic pregnancy other (specify)				23d. Date of deliv	rery Day Year
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sion o	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director,	ertification;	27. Manner of Death  1 Natural 5 Pending investigation		rime of njury	28c. Injury Work	rat ⟨? Yes 2 ☐ No	28d. Describe	how inju	iry occurred	
DİXİ	rs after d rs after d ral Direct	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street	t, factory, office		28f. Location ( City or To	Street a wn, Stat	nd Number or Run e)	al Route Number.
	he Hospl n 24 hou he Funer bietely fill	edical	29a. Certifying Physic (Check only one)	cien: To the best of my knowledge er: On the basis of examination and and manner stated.	death of dea	ccurred at the tim stigation, in my op	ne, date and pla pinion, death oc	ce, and due to the curred at the time,	cause(s date an	s) and manner as s id place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Z	29b Signature and title of certifier	6. Gelis Tu		29c. License	2160		1	ate signed (Month,	
1	8		30. Name and address of person who con	epleted cause of death (Item 23a) (	(Type, Pri	-	er 1	tuence	Ų.	Jestmix	site
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature						ΥW	ALL VALO
OH	MF FF Roy ETE	OC+		2005 ORIG	GINAL	and .					- Mari

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	ertificate of			giene	15	39080
,	A 1 1 1 1 1 1 1 1 1	5	Decedent's Name (First, Middle, La.	st)				2. Date of Dea	ıth		3. Time of Death
	Physici	_	CHARLES	PAUL I	PPOLITO, J	r		NOV 2	Day 29 200	Year 5	12:04 PM
100	/Medic Examin	_	4a. Facility Name (If not institution, give	e street and number	)		or Location of Deat			y of Death	+4.04
		27	NATIONAL NAVAL				THESDA		МО	NTGOM	ERY
	Funeral Director		5. Social Security Number 6. S 228–96–4578 1	ex X M 2□F	ge (In yrs. last birthday 41 Yrs.	Months Days			1964	9. Birth	place (State or Foreign
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation					10d. Inside City Limits
	Aaryla Febor	5	VA 10a. State FAIRFAX		SPRINGFIELD						1 ☐ Yes 2 X No
	with the Page or 28a-	i Director	10e Street and Number HORSE (C)	URI		10f. Zip Code 22153	}		10g. Citizen of	What Cou	ntry?
036	should be filed within 72 hours after death with the Maryland Nantal Hygiene marked other than "natural" or ltems 23a or 28a-f ehow marked other than "natural" or ltems 23a or 28a-f ehow imatic event, it e Marical Examinar must be neillied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Althed Forces 1 X Yes 2 If Yes, Give Year or Dates:	<sup>№</sup> 14986 <sup>22</sup> ,	. Was Decedent of If Yes, specify Cub		Specify Yes or No- to Rican, etc.)	14. Ra Bla Speci	ice - Americack, White,	etc.
<u>7</u>	72 h "natu	etec	15. Decedent's En (Specify only highest gra		16a. Dec (Giv	edent's Usual Occu e kind of work done DO NOT use retire	pation during most of wo	orking	16b. Kind of E	Business/In	dustry
12	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) <b>OF</b> .	FIOR	90)		ARMY		
Maryland 21215-0036	illed Hygi other	Be	17. Father's Name (First, Middle, Last, CHARLES PAUL IPPOLIT	D, SR.				me (First, Middle,		me)	
Mary	permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Hem 27 is marked ent injury or other traumatic e 2000.	<u>P</u>	19a. Informant's Name/Relationship ( SUSAN IPPOLITO (WIFE			ling Address (Stree					Code)
Baltimore,	ages 1 ar nnt of Hea nt: If Item: y or othan		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		20b. Place of Disp ARLHY STONY CEMETERY	position (Name of	Jan.	Date 30, 2006	20c. Location		own, State
Baltır	permit. P Depertme Importan eny injur		21. Signature of Funeral Service Lice			22. Name and Addr 5308 BACKLI	ess of Facility I	EMAINE FUN RINGFIEID,			
· .	Physician /Medical Examiner		23a. Part 1. Enter the disease, or some shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. META  Due to (or a	ed the death. Do not e			c or respiratory ari	rest,		Approximate Interval Between Onset and Death
8760,	icate be executed physicien and s the burial-transit	dicai Examiner	Sequentially list conditions, if any, reading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):						
P.O. Box 68	death certil e ettending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnand □ Other (specify) _	БУ			ate of deliver	ery Day Year
	uires that signed b Id be deta	P	Part II. Other significant conditions of	contributing to death	but not resulting in the	underlying cause gr	iven in Part I.	23e. Did to	v		he cause of death?
Vital Records,	: The law requires that the cete has been signed by the page 2 should be detache	Completed						24a. Was a autop perfor 1 \( \text{Yes} \)	sy	Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of 2  No
ĬĬ.	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		10	ther	ath (Check only or			
ou of	ding Phys I. After this funeral di	tlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of In (Month, D		of 28c. Inju	4 🗀 Nursing r	Home 5 Resid			у)
Division of	l or Attending efter death. Director: After I in by the fune	Certification;	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Ir	njury - At home, farm, s atc. (Specify)			28f. Location (S City or Tow		ber or Rura	al Route Number,
	Hospital 24 hours Funerel stely filled	Medicai Co	29a. Certifier (Check only one)  2  Medical xar	nysician: To the bas niner: On the bas and manne s	t of my knowledge; de of examination and/or stated.	ath occurred at the tinvestigation, in my	ime, data and place opinion, death occ	E; and due to the c urred at the time, o	auto(s) and T date and place	and due to	tated. o the cause(s)
	To the within 2 To the complet	₩	29b. Signature and title of pertifier	7	`	29c. Licen	ise number	ž	29d. Date sign	ed (Month,	Day, Year)
	C/			1		0101	237286 (\	VA)	Nov	30	7005
5 \$	7	8	30. Name and address of person who	completed cause of	death (Item 23a) (Type			ATIONAL N			
1	J		RICHARD A. CATHER	INA LCDR	MC USN			ETHESDA M			
			Of Date Glad (Month Day March	20 01-	tenda Cianatura						

DHMH 17 Rev 1/2001

Registrar

			For State Registrar	State of	of Maryla		artmen <i>rtificati</i>			ınd M	ental Hyg	iene eg. No.	005	39081
×	Physici	an	1. Decedent's Name (First, Midden Mildred A. Je	nes						610	2. Date of Deal Month	Day	Year	3. Time of Death
) 2	/Medio		4a. Facility Name (If not institution Saint Josep	on, give street and nu	imber)	tan	4b. City,	Town, or	Location o	f Death	IVEMBER	7	2005 County of Death	1 = 16 -
	Funeral		5. Social Security Number	6. Sex		s. last birthday)	If Under		If Under 2	W S O T	8 Date of Birth	14	Balt:	place (State or Foreign
	Director		219-58-5566 Usual Residence of Decedent	1□M 2\(\overline{\pi}\)F	93	Yrs.	Months	Days	Hours	Min.	May 13,	T91	.2 Mar	"Tand
	inyland show	_	10a. State 10b. Count			City, Town or Lo	ocation							10d. Inside City Limits
	the Market 1	recto	MD Balti  10e. Street and Number	more	11	monium	10f. Zip	Code			1	Og. Citizo	en of What Cou	1 ☐ Yes 2 No
	ath with	Funeral Director	1 Elphin Court				210					SA		
38	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23s or 28s-f show aumatic event, the Madical Examinational be notified at	by	11. Marital Status  1 Never Married 2 Ma 3 Widowed 4 Divorce	Amed F	2 XNo		Was Deced If Yes, spec 1 ☐ Yes :	ofy Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: Wh	
2-G	"natur	Completed	(Specify only high	nt's Education ast grade completed,		(Give	dent's Usua kind of wor DO NOT us	rk done d	urina most	of working	ng	16b. Kin	d of Business/I	ndustry
212	ad withir giene. er than	Comp	Elementary/Secondary (0-12)		1-4or 5+)	Secre							ce of Ma	aryland
land	ed at a	To Be	17. Father's Name (First, Middle not known Al	, <sub>Last)</sub> brecht					18. Mothe Ame I		(First, Middle, I not kn		Sumame)	
Maryland 21215-0036		-	19a. Informant's Name/Relation								Route Number			ip Code)
	es 1 and of Health fitem 27 r other tr		Stephen W. Jon 20a. Method of Disposition		20b	Place of Dispo	sition (Nan	ne of	9)	D			13 ation - City or T	own, State
Baltimore,	permit. Pages Department of Important: if it eny injury or o		1 Burial 2 Cremation 4 Donation 5 Other (	Specify)	State WO	odlawn	Cemet	ery	1	12/5/	'05 W		awn, M	
Ba	Depar Impor		21. Signature of Fun ral Service	Eiceniee Orn			2. Name an Ruck T				Home		)50 Yorl wson, I	K Road MD 21204
	. € - * * 		23a. Part1. Enter the disease, of shock, or heart failure. Lis						g, such as	cardiac oi	respiratory arre	est,	-	Approximate interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to	(or as a cons	INFA								
Ц	Examiner	er	Sequentially list conditions, if any leading to immediate	b	Or as a cons	EL DBS	TRUCT	rion						
	scuted ind transit	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last			ED LE	ET IN	NGUI	NAL	HER	NIA			
8760,	cate be executed physicien and the burial-transit	dicai Ex	resulting in death) Last	d. Due to	(or as a cons	equence of):								
9	entificat ding phy se as th	· ·	IF FEMALE:	23c. If yes, ou	stcome of area	Inanov								
.O. Box	at the death certifi by the attending I tached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 Live	birth 2 ☐ Fe nant at time o	etal death 3	□Ectopic pr □ Other (sp					23	3d. Date of deliving Month	very Day Year
ords, P	The law requires that ate has been signed b bage 2 should be deta	ρ	Part II. Other significant condit	ions contributing to d	leath but not r	esulting in the u	nderlying c	ause give	n in Part I.		23e. Did tob		,	the cause of death?
Il Records,	: The law recate has be page 2 sho	Completed								_	24a. Was an autops perform	y	24b. Were aut prior to codeath?	opsy findings available ompletion of cause of
Vital	ysician: Th is certificate director, pag	o Be	25. Was case referred to medic examiner?  1  Yes 2	Hospital: \	Inpatient 2	☐ ER/Outpatie	nt 3□ DO	A Othe	r		(Check only on		□Other (Spec	fv)
on of	ding Physician: h. After this certific funeral director,	tion; T	27. Manner of Death	28a. Date (Mor		28b. Time o		8c. Injury Work		2	8d. Describe ho			
Division	ten leet tor: the	Certification:	3 ☐ Suicide 6 ☐ Could	mined 286. Plac	e of Injury - At ling, etc. (Spe	home, farm, st					8f. Location (St. City or Town		Number or Rui	al Route Number,
	To the Hospitel or At within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier 11 Certify (Check only one) 2 Medica	ing Physician: To th I Examiner: On the l and man	e best of my k pasis of exami nner stated.	nowledge, deat nation and/or in	h occurred vestigation,	at the tim	e, date and inion, deat	d place, a	nd due to the ca	iuse(s) a ate and p	nd manner as place, and due	stated. to the cause(s)
1	To the within To the comp	ž	29b. Signature and title of certification	La Land	MI	)		. License			2!	ed. Date	signed (Month)	Day, Year)
,	7		30. Name and address of person	who completed cau	se of death (It	em 23a) (Type,		240	34			11/2	-1/0)	
	Sta	to.	IMOTHY LOW,  31. Date filed (Month, Day, Yea.		Q1 OS	LER DF	IVE	TOWS	30N.	MAR	YLAND	212	04	
***	Registr		DEC 0 5 21	005 Aras	A D.	nature								

			For State Registrar	State of M	-	-	artment of H		nd Mental Hy	/gien Reg. Ñ	000	3908	2
			1. Decedent's Name (First, Middle	e, Last)					2. Date of D Month		ay Year	3. Time of D	
E	Physicia /Medic Examin	al	Robert Gordon		·)		4b. City, Town, or	Location of	Novemb	er 3	30, 2005 c. County of Dea	7	РМ
	LXamiii	Ci	3618 Chadwic	k Court			Pasad	ena			Anne A	rundel	
	Funeral Director		5. Social Security Number 216-16-3008		ge (In yrs. last bir 84	thday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of B (Month, D Aug. 15	irth ay, Year	9. Bir 921 Ma	rthplace (State or Fountry)	Foreign
	P.		Usual Residence of Decedent		10 00 7							104	I i-it-
	show	_	10a. State 10b. County		10c. City, Town	n or Lo	cation					10d. Inside City 1 ☐ Yes 2	
	8a-f	Director		e Arundel	Pasa	den				10= 0	itizen of What C		-
	with ti	吉	10e. Street and Number 3618 Chadwick	Count			10f. Zip Code Pasad	one		10g. C	USA	ountry?	
	eath	eral	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.			in? (Specify Yes or N	0-	14. Race - Am	erican Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Exact for most be notified at once.	by Funeral	1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed Forces ied 1 ☐ Yes 2 ☐ If Yes, Give	i? No	i	f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	n, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)		Black, Whi	White	
2	72 hc natur	Completed	15. Deceden (Specify only highes	t's Education st grade completed)	16a.	(Give	dent's Usual Occupa	furina most i	of working	16b.	Kind of Business	s/Industry	
2	ithin ne.	mple.	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT use retired	)		77.7			
7	lled w tygier her ti	S	12 17. Father's Name (First, Middle,	( ast)		Sa.	lesman	18 Mother	's Name (First, Middl		ectric C	orp.	
and	be f ntal h ed ot	Be	Mason H. Kornm						uby Marsh	.,	5511141115/		
Š	hould de Me mark	ဥ	19a. Informant's Name/Relations		19b	. Mailir	ng Address (Street a		or Rural Route Num	ber, City	or Town, State,	Zip Code)	
<u>8</u>	id 2 s lth an 27 Is :								Pasadena,	-			
	f Heal		Patricia A. Wi 20a. Method of Disposition		20b. Place of	f Dispo	sition (Name of natory or other place		Date	20c.	Location - City of	r Town, State	
E O	Pages ent of nt: If I		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		A		Cemetery		2/5/2005	Woo	odlawn,	Maryland	
Baltimore,	permit. Departm Importa any inju		21. Signature Funeral Service	vicens >			. Name and Addres				• - 1	<b>-</b>	
m	9 9 5 8 9	10	Hebeev	COS			vitzke Fu 1630 Edmo	neral ndson	Home of C Avenue; C	ator	nsville, nsville,	MD 2122	8
			23a. Part1. Enter the disease or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do line.	not ent	er the mode of dying	g, such as c	ardiac or respiratory	arrest,		Approximate Interval Betwee Onset and De	
ļ.	Physician		Immediate Cause (Final disease or condition	a End st	age rena	1 d	isease					_years	auri
	/Medical Examiner		resulting in death)		is a consequence								
	LAGITITICI	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Dement	ia is a consequence	of):						years	
	ted nsit	Examiner	Cause (Disease or injury	Anomia	is a consequence	0.,.						voore	
	and and al-trai	xar	that initiated events resulting in death) Last	c. Anemia Due to (or a	is a consequence	of):						years	
1760,	ate be executed hysician and the burial-transit	call		d. Degene	rative a	rth	ritis					years	
89	tificat ng phy as th											-	
.O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death at time of death		Ectopic pregnancy Other (specify)				23d. Date of de Month	elivery Day Ye	ear
۵.	that the ed by detac		Part II. Other significant condition	ons contributing to death	but not resulting in	in the u	nderlying cause give	en in Part I.	23e. Did	tobacco	use contribute t	to the cause of dea	ath?
ds,	Se UE	d by	Peripheral Vas	cular Disea	se				1	Yes :	2 <b>⊠</b> No 3□P	Probably 4 Un	known
Record	w require been sign	ompleted	Benign prostat	e hypertrop	hy				24a. Wa		24b. Were a	utopsy findings av	/ailable
Be	9 7 9	d Wo				o h	orrol dian	200		opsy formed? 2 [X]N	death?		use of
Vital	ilclan: Th certificate rector, pag	O	Bilateral hydr 25. Was case referred to medica		ISCHEMI	C D	Ower drse		of Death (Check only			- A- 110	
<b>1</b>	S S	ToB	examiner? 1 ☐ Yes 2 ☒No	Hospital: 1 🗌 Inpa	tient 2 ☐ ER/Ou	utpatier	nt 3 DOA Othe	er: 4 □ Nur:	sing Home 5X Re	sidence	6 □Other (Spe	ecify)	
ion of	ftei ftei na	ertification:	27. Manner of Death  1 X Natural 5 ☐ Pendir 2 ☐ Accident investi	igation	njury 28b. Day Year)	Time o Injury	Worl	yat k? Yes 2 □ N	28d. Describe	how inj	ury occurred		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fo	O	3 Suicide 6 Could 4 Homicide determ	nined 288. Place of	njury - At home, fa etc. (Specify)	arm, st	reet, factory, office		28f. Location City or To			Rural Route Numbe	er,
	he Hosp in 24 hou he Funel pletely fil	edical	(Check only 2 Medical one)	ng Physician: To the be Examiner: On the basis and manner	of examination ar		vestigation, in my o	pinion, death		, date a	nd place, and du	e to the cause(s)	
	To To Com	×	29b. Signature and title of pertific	~ Keil	lly,	M	29c. License D547				ate signed (Mon 12/1/05	nn, vay, rear)	
	8		30. Name and address of person Allen Reilly	, M.D. 4 Ea	st Rolli			s, su	ite 307, E	alt:	imore, M	D 21228	
	Regist		31. Date filed (Month, Day, Year, DEC 0 5	2005 32. Regii	strar's Signature	do	ente						
Dł	HMH 17 Rev 1/2	2001				GIN							

Amend item/20c, perfn, C850, 12/5/05 TI State of Maryland / Department of Health and Mental Hygiene 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DECEMBER KAT7 1 2005 ARLENE 9:30A /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY Under 1 Year If Under 24 Hrs. 8. Date of Birth onths Days Hours Min. 02/11/1920 9. Birthplace (State or Foreign Country) NDIANA 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Months Days 1 □ M 2 🕅 F 314-09-4192 85 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County r then "naturel", or Items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MONTGOMERY SILVER SPRING the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11013 BUCKNELL DRIVE 20902 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 should be filed within 72 hours after a and Mental Hyglene.
Is marked other then "naturel", or Itel 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) PATIENT AFFAIRS BÉTHESDA NAVAL HOSPITAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CIRALSKY **RACHEL** UNKNOWN ISAAC 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 is rr eny injury or other treum <u>once</u>. BERNARD KATZ / HUSBAND 11013 BUCKNELL DRIVE-SILVER SPRING, MD 20902 20c. Location - City or Town, State **Rosedale** 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) SHAAREI ZION CONG. 12/02/2005 BALTIMORE MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS., INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cerebral Pnysician Vasaular is che mia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the burial-transit certificate be executed Due to (or as a consequence of): attending physician for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 051-258 W w. s 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Boc Kulle

DHMH 17 Rev 1/2001

State

Registrar

Montrese Load

6121

32. Raistrar's Signature

MO

2005

31. Date filed (Month, Day, Year)
DEC 0 5

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiefie | | 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Edward Lynch 2:10 P M December 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Genesis Eldercare-Heritage Center Dundalk If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) Min. May 1, 1918 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country, WV **™** M 2 F 220-03-9794 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits or 28a-f ahow raf, or Items 23a or 28a-f ahov Examiner must be notified at 1 Tyes 2 No Baltimore Dundalk MD. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 1767 Brookview Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Healinh and Mental Hygiene.
Important: If itam 27 is marked other than "natural", or flam any injury or other transment. Black, White, etc. 1 TXYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes > No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Welder Shipyard 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Maye Reynolds Howard Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gale Haselbach 9509 Hallhurst Road, Perry Hall, MD. 21236 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Jesus Cem. 4 ☐ Donation 5 ☐ Other (Specify) 7, 2005 Dundalk, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 23a. Pari 1. Enter the diseale, or complications that caused the death. Of not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TA Z Physician Due to (or as a consequence of /Medical Examiner Sacuratieity list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of HYPERTENSION The law requires that the death certificate be executed and to (or as a consequence of) attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the a 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Dunknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? has this certificate 2 No 1 ☐ Yes 2 NO 1 Tyes or Attanding Phyaician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 D Other: 4 Vursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Diractor: After tural 5 Pendina 2 No death. 1 Tyes investigation Accident in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Division of Vital Records, P.O. Box 68760. To the Funeral

> Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Jame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

			For State Registrar	Amend	State  Items 24	of Mar ia,25	yland / De <b>per Dr</b>	epartme C850 Certifica	nt of b	lealth 5/059 Death	and M hb	lental Hy	giene	005	390	85
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	Funeral		5. Social Security No		6. Sex 1 ☐ M 2 🔀 F		In yrs. last birthe 7 1 Yr	Month	er 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 4 – 28 -	rth ay Year)	9. Bi	thplace (State ountry)	or Foreign
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15-	within 72 hours after death with the Maryland ene. than "natural", or frams 23a or 28a-f show the Medical Erain" ar marke notified at	lete	(Speci		t's Education st grade complete	d)	((	ecedent's U: Give kind of t fe. DO NO7	rork done	during mos	t of worki	ng	16b. Kin	d of Business	/Industry	
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AEM 05-08033 Castello Lambert

Amend Tem 208, periff, 630, 1275 (b) III. Ensure All Copies Are Legible.

			1 - For State Registrar		State o	if Maryl		artment of H <i>rtificate of l</i>			ien <del>o</del> () ()	5	39086
			1. Decedent's Name		st)					2. Date of Deat	h	Vone	3. Time of Death
	Physici /Medio		Castello L.	Lambert						Novembe	r 28, 20	005	6:17 P M
	Examin	er	4a. Facility Name (If I	not institution, giv	e street and nu	mber)		4b. City, Town, or	Location of Deal	th	4c. County	of Death	
			Good Sama 5. Social Security Nu	aritan H		7 Age (In )	yrs. last birthday)	Baltimor If Under 1 Year	e City	8. Date of Birth	n/s		place (State - Free -
	Funeral Director		229-84-6902	1	_M 2 € F	4. Age (#/)	V	Months Days	Hours Min		Year) 7	Virgi	place (State or Foreign intry) in1a
	land		Usual Residence of D 10a. State	10b. County		10c	. City, Town or Lo	ocation					10d. Inside City Limits
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	or 28s	Director	10e. Street and Num	ber				10f. Zip Code		1	0g. Citizen of W	hat Cou	intry?
	23a c	aiD	6614 Touchs	stone Ct.				2121	4		USA		
	tens tens	Funerai	11. Marital Status		12. Was Dec	orces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		- Ameri	ican Indian, . etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other treumatic event, the Medical Examinar must be notified at ODGE.	þ	1 XNever Marrie 3 Widowed 4		1 🗌 Yes If Yes, Gir Year or D	ve		1 ☐ Yes 2 No	Specify:		Specify:		
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Baltimore,	Depart Import any in		21. Signature of Fund	eral Service Licer	nsee Ann			s of Facility  I Home P.A	. 638 N Gil	mor St B	otte!	MD 21217	
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	/Medical		resulting in death)	-	a. Due to	(or as a con	sequence of):	10/10/0	THE CONE	Denino	4		
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o	The law requires that the death cert lie has been signed by the attendin age 2 should be detached for use.	Physician/M	in the past 12 m 1 □ Yes 2 □ 9 € Unknown			ant at time		Other (specify)			Mon	.h	Day Year
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N N	al or Attending Phy after death. I Director: After this d in by the funeral d	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place	of Injury - A	at home, farm, str	eet, factory, office		28f. Location (Str City or Town	eet and Number	or Rura	al Route Number,
ō	Hospital or A 24 hours after Funeral Dire tely filled in by				- Julian	ing, o.o. (Dp	ochy)			City of Town	Siate		
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medicai	29a. Certifier 1 (Check only 2 one)	☐ Certifying Ph CXMedical Exam	niner: On the ba	best of my asis of exam ner stated.	knowledge, death nination and/or in-	n occurred at the tim vestigation, in my op	e, date and place pinion, death occu	e, and due to the ca irred at the time, da	use(s) and man te and place, ar	ner as si nd due to	tated. the cause(s)
	To the within 2 To the Complet	Me	29b. Signature and til	tle of certifier			) ^ ^	29c. License	number	29	d. Date signed	(Month,	Day, Year)
}	d		tat	wille	onic	a-to	Ille.	OCM	E		Novembe	r 29	9, 2005
	1		30. Name and address	ss of person who	completed caus	e of death (	Item 23a) (Type,	Print)	М- 3	1 01 001			
	Sta	te.	31. Date filed (Month)	, Day, Year)	111 P	enn St Sgistrar's Si	reet, B	altimore,	marylan	a 21201			
	Registr				2005	Musica	gnature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 1tem/5, per FH, C850, 12/5/05 TT

State of Maryland / Department of Health and Mental Hygiene 0 0 5

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** NOVEMBER 29, 2005 11:05 P <sup>™</sup> LIPSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PICKERSGILL NURSING HOME TOWSON BALTIMORE MODSecurity Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F <del>- 022</del>-20-8017 75 Yrs. RΙ Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Funeral Director BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12000 TRALEE ROAD 21093 U.S.A. Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
snt: If item 27 is marked other then "naturel", or Items 23 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 NOREAN HAS, Give KOREAN Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) **JUDGE** LEGAL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be IRVING LIPSON MOLLYE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12000 TRALEE ROAD - LUTHERVILLE, MD 21093 BARBARA LIPSON / WIFE 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State BALTIMORE HEBREW 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Importent: If any injury or once. 12/02/2005 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MAN Physician ean /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Deal 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2/ Accident 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 2005 Registrar

			1 - For State Registrar	State of I	Marylan		artment of H		nd Me	ntal Hy	giene		5 3	39088
	J 5	À	Decedent's Name (First, Middle, La	st)					2.	Date of D	eath			3. Time of Death
	Physici		Ray M. Mo	nk						Month No Verr	Da	27	Year	16:58 pm
1	/Medic Examin		4a. Facility Name (If not institution, given		er)		4b. City, Town, or	Location of		, 40 (4)			of Death	
		E/C	Union Memorial Ho	spital			Baltimor	·e						
	Funeral →		5. Social Security Number 6. S	Sex 7.	Age (In yrs. I	iast birthday)	If Under 1 Year Months Days	If Under 24 Hours	4 Hrs. 8. Min.	Date of Bi (Month, D	rth av. Year)		9. Birthpla Country	ce (State or Foreign
в	Director		110-30-4/35	IXIM 2□F	67	Yrs.	Working Days	Hours			6, 1		North	"Carolina
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	cation						100	d. Inside City Limits
	Aaryli sho	ō			Jama								1.00	1 XYes 2 No
	28a-	Director	New York Queens 10e. Street and Number		Jailla	ıca	10f. Zip Code				10a Cit	izen of V	Vhat Countr	w2
	with Sa or		134-29 166th Pla	oo Ant	5 B		11434					_	tates	<b>y</b> ,
	ns 23	Funerai	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13.	Was Decedent of Hi	spanic Origi	in? (Specif	y Yes or N			e - Americar	n Indian,
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at	by Fun	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Date	No No	'	f Yes, specify Cubai 1 ☐ Yes 2X No	n, Mexican, I Specify:	Puerto Rio	án, etc.)			k, White, et	C.
9-10	2 ho	Completed	15. Decedent's E			16a. Dece	dent's Usual Occupa	ition	- (		16b. K	ind of Bu	siness/Indu	
215	within 7 ene. than °n	old L	(Specify only highest gr.	College (1-4	or 5+)	life.	NOT use retired,	) )	ot working					
	filed with Hygiene. other than	Con		4		Asst.	Principle						Work	
nd	be filed to the other of the ot	Be	17. Father's Name (First, Middle, Last	)				18. Mother:	s Name (F	irst, Middle	, Maiden	Sumam	Θ)	
yla	should nd Men marke	မ	Robert Monk					Julia						
Maryland	2 sho	0 19	19a. Informant's Name/Relationship (	•			ng Address (Street a							
	s 1 and 2 of Health item 27 i	11	Alice F. Monk (W	ife)	20b B		9 166th P	'1., A	pt. 5					
201	Pages nent of h ant: If ite ury or of		M☐Burial 2 ☐ Cremation 3 ☐		ite C	emetery, crer	natory or other place						City or Town	
Baltimore,	it. Partimer rtmer rtmant njury		4 Donation 5 Other (Special		#CC03		s Cemeter	)	2/2/05				ck, N	Y
Ba	permit. Pages Department of Important: If is any injury or once.		21. Signature of Funeral Service Lice	Besset	te	17	Name and Addres Foster-P 9-24 Lind	len Bly	vd.,	<u>Jamai</u>	ca,	e NY 1	1434	
ý			23a. Part1. Enter the disease, or com shock, or hear talkine. List only	plications that cause one cause on each	sed the death	n. Do not ent	er the mode of dying	g, such as ca	ardiac or re	espiratory a	rrest,		l I	oproximate nterval Between
100	Physician		Immediate Cause (Final disease or condition	a. Co	ngestiv	e hea	rt failure	2						Onset and Death
W.	/Medical Examiner		resulting in death)				_							3
ją.	1	<u>.</u>	Sequentially list conditions,	b. Co	as a consequ	y arte	ery disea	se						34 years
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D40 10 (01	as a consequ	derice or).								
	axecu al-tra	xar	that initiated events resulting in death) Last	C. Due to (or	as a consequ	uence of):								
8760,	ficate be executed physician and s the burial-transit	dical		d										
.89	ificati g phy as the	edic		· ·							1			
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □Live birth 4 □ Pregnan 9 □ Unknown	2 ☐ Fetal t at time of de	death 3	Ectopic pregnancy Other (specify)					23d. Date Mor	e of delivery oth D	ay Year
<u>α</u>	res that tigned by		Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the ur	nderlying cause give	n in Part I.		23e. Did	tobacco u	ise contr	bute to the	cause of death?
Vital Records,	The law requires that ste has been signed b page 2 should be deta	ed by								1 🗆	Yes 2	□No	3 Probab	bly 4 Quinknown
000	sw requir s been si s should	Completed								24a. Was		24b. V	Vere autops	y findings available
Re	The lav ete has page 2 :	mo									ormed?	d	rior to comp leath? Yes 2	oletion of cause of
ta		0	25. Was case referred to medical					26. Place o	of Death (C	1 Yes	2 Z No	<u> </u>	165 2	
<b>1</b>	S S P	To B	examiner? 1 Tes 2 No	Hospital: 1 [[]]	atient 2 □ I	ER/Outpatien	t 3 DOA Othe	r: 4 🗆 Nurs	ing Home	5 🗆 Res	dence	6 □Othe	or (Specify)	
n of			27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of I (Month,	njury Day Yeer)	28b. Time of	28c. Injury Work			I. Describe				
Ö	Attending r death. •ctor: Afte	atic	2 Accident investigation					res 2 □ No	0					
Division	or Attendated after death Director:	Certification:	3 Suicide 6 Could not be determined	200. Flace U	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office		28f.	Location ( City or To			er or Rural F	Route Number,
	pital urs a eral C		29a, Certifier 1/D Certifying Pl			4-4 1 4								
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	ledicai	(Check only 2   Medical Examone)	miner: On the basis	s of examinat	tion and/or inv	occurred at the time vestigation, in my op	inion, death	occurred :	at the time,	date and	and mar I place, a	aner as state and due to th	ed. ne cause(s)
	To	Σ	29b. Signature and title of certifier	1 000	> M	D.	29c. License		6 5			_	(Month, De	
	1			3	J-1-	· .	A1 24	13894	0-10	,	20	Veinl	per, 27	7,2005
9	3 /		30. Name and address of person who					14:000	0 117	n n 1:	215			
	) Sta	to	31. Date filed (Month, Day, Year)	l, Union	M emor		piral, Da	ltimor	C, 141	U 21	410			
1 2	Registr	- 1	DEC 0 5 2	2005	EAST A	H. A	all)							

[ 			For State Registrar	State of	Marylan	d / Depa	artment <i>rtificate</i>	of He	ealth a	and M		giene Reg. No.	00		3908	39
4	Physicia	an	1. Decedent's Name (First, Mide								<ol><li>Date of De Month</li></ol>	ath Day	,	Year	3. Time of D	eath
	/Medic	_	Clifford	Dale		ller	T				ovembe:			005	0820	М
-	Examin	er	4a. Facility Name (If not instituti		θr)		4b. City, To	_	ocation o	of Death			County			
1.0	Funeral	386	411 Montrose 5. Social Security Number		Age (In yrs.	last birthday)	If Under 1		If Under	24 Hrs.	8. Date of Bir (Month, Da		rinc		Orge's lace (State or I ltry)	Foreian
	Director		232-72-2548	1 € M 2 □ F	60	Yrs.	Months	Days	Hours	Min.	July 14	y, Year) $1$	945	West	t Virgi	nia
	p ,		Usual Residence of Decedent		100 Cit	y, Town or Lo										
	ehov	7	10a. State 10b. Count				ocation							1	0d. Inside City 1 □ Yes 2	
	the M	ecto	MD Prine	ce George's		Laure1	10f. Zip C	Code		· .		10a Citi	zon of IA	hat Coun	1   Yes 2	X
	72 hours after death with the Maryland natural', or Items 23s or 28s-f ehow digal Examinar must be rediffed at	Funeral Director	411 Montrose	Avenue				707					SA	mat Coun	uy:	
	ms 23	era	11. Marital Status	12. Was Decede		.S. 13.			panic Ori	gin? (Spec	city Yes or No lican, etc.)		14. Race		an Indian,	
9	or Ite	Fur	1 XNever Married 2 ☐ Ma	Armed Force arried 1 Tes 2 If Yes, Give			If Yes, specifi 1 ☐ Yes 2		, Mexican Specify:		lican, etc.)	}		k, White,	etc.	
93	ural',	d by	3 Widowed 4 Divorce	Year or Date	es:		10 105 21	AINO	зреспу.				Specify.	Wh	nite	
5-	natu	Completed		ent's Education lest grade completed)		(Give	dent's Usual kind of work DO NOT use	done du	ion I <i>ring m</i> osi	t of workin	g	16b. Ki	nd of Bu	siness/Ind	dustry	
12	within ene. then	dmo	Elementary/Secondary (0-12)	College (1-4	or 5+)		vicema					Не	ati	ng &	Air	
2	be filed within 72 hours after death with the Marylan stal Hygiene. Ind other then "natural", or Items 23a or 28a-f show event, the Medical Examination in the rectified at	Be Co	17. Father's Name (First, Middle	e, Last)					18. Mothe	er's Name	(First, Middle,				****	
lan	should be nd Mental marked c	To B	Daniel W. Mil	ller					Fran	ces 1	lae Cal	.1				
Maryland 21215-0036	2 short		19a. Informant's Name/Relation				-				Route Numbe			State, Zip	Code)	
≥, ≤	and ealth m 27		Barbara Bevi	ns (Siste	-				97 B1		11, WV					
Baltimore,	ges 1 If it of H or of		20a. Method of Disposition t X Burial 2 ☐ Cremation		ate C	lace of Dispo emetery, cre	matory`or oth	ner place,			ate .				wn, State	
臣	it. Pa irtmer irtant njury		4 ☐ Donation 5 ☐ Other (		Mil	ller C	emeter; 2. Name and	-		11/26	/05	Со	alda	le,	WV	
Ba	permit. Pages I and 2 should be Department of Health and Menta important: If Item 27 Is marked eny injury or other traumatic ev		21. Signature of Furneral Serve	apple 1	QU	(	Craven	s-Şh	ireș	Fune	ral Ho Rd. Bl	me .				
	1.5	1	23a. Part1. Enter the disease,	or complications that cau	sed the deat	h. Do not en	ter the mode	of dying,	neri such as	cardiac or	respiratory a	uefl rest,	eld	W V	Approximate	
	Physician		shock or heart failure. Li												Onset and De	
F.	/Medical		disease or condition resulting in death)	a. HEA	as a conseq	uence of):	-7									
184	Examiner		Sequentially list conditions.	b												
	p tig	Examiner	if any, leading to immediate cause. Enter Underlying		as a conseq	uence of):										
	and I-tran	xam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):										
8760,	ate be executed hysicien and the burial-transit	ical E														
9	ificate g phys			a.												
Box	death certifica e attending ph d for use as th	N/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			75					2	3d. Date	of delive	ry	
m .		Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		n 2∏Feta tattime of d		∃Ectopic prec ∃Other (spec						Mon	th	Day Yea	ar
P.O.	that the de ned by the a detached t	Phy	9 □Unknown													
	8 5 8	þ	Part II. Other significant condi	tions contributing to deal	h but not res	ulting in the u	nderlying cau	use given	in Part I.			obacco u /es 2[			e cause of dea ably 4 <b>⊠</b> Uni	Ì
Records,	w require been sig should b	Completed														
Rec	e la has	mp									24a. Was autop perfo		p	ere autor for to con eath?	osy findings ava npletion of cau	se of
la	icien: Th certificate rector, pag	ပို	25. Was case referred to medic	al					OC Diago	of Dooth	Check only o			Yes	2□ No	
of Vital	Physicien: this certific ral director,	To B	examiner? 1-☑ Yes 2 ☐ No	Hospital:	atient 2 🗆	ER/Outpatier	nt 3 DOA				e 5 ☐ Resid		S f⊠Othe	r (Snecifi	Scana	
10	ding Physicien: h. Alter this certific funeral director,		27. Manner of Death	28a Date of		28b. Time o	f 280	c. Injury a Work?	at	2	3d. Describe h	now injur	occurre	d d	Decire	
Sio	Attending r death. ector: Alter by the fune	atic	CALL TOOLGOIN	tigation 11/20/		Found 8	SAM		es 2 🖽	No S	VBTECT	FE	LL			
Division	l or Atten after deat Director:	Certification:	3 ☐ Suicide 6 ☐ Coul- 4 ☐ Homicide deter	ZKA PIACA OI	Injury - At ho etc. <i>(Specif</i> )	ome farm sti	reet, factory,	office			City or Tov	vn, State,	}		Route Numbe	ır,
Ω	lospital		200 Continu		510€				4-1		II HONT					0
	Hospital 24 hours a Funeral I etely filled	edical	29a. Certifier 1 Certify (Check only one)	ring Physician: To the be al Examiner: On the basi and manner	s of examina	tion and/or in	vestigation, in	n my opir	nion, deat	d place, al th occurre	d at the time,	cause(s) date and	and mar place, a	ner as st nd due to	ated. the cause(s)	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Me	29b. Signature and title of certif				29c.	License	number			29d. Dat	signed	(Month, I	Day, Year)	
			<b>)</b>	w D			00	CME				Nove	mber	2. 21	, 2005	
1			30. Name and address of perso	n who completed cause	of death (Item	1 23а) (Туре,	Print)									
2			ANA	RUBIO F	0		111	. Per	n St	reet	Balti	more	e, Ma	aryla	and 2120	01
	Sta Registr	_	31. Date filed (Month, Day, Yea	5 2005 32. R	istrar's Signa	ture	back	•								
45			DEGI	J J LUUJ M	the seems.	Jest 14										

		•	1 - For State of Market State of Market State Registrar	aryland / Depa <i>Cer</i>	artment of He tificate of D	ealth and M Death		jiene () () 5	39090
	Dharaini		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death
	Physici /Medic		OLEN E. MERSON					r 30, 2005	6:00 a M
	Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	Location of Death		4c. County of Dea	
			1130 12th Street  5. Social Security Number	e (In yrs. last birthday)	Laurel  If Under 1 Year	If Under 24 Hrs.	9 Date of Birth	Prince (	
	Funeral Director		213-16-2583 <sup>1</sup> XX <sup>2</sup> F	35 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day NOV 11,	Year) Co 1920 Ma	thplace (State or Foreign ountry) aryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	Maryl f sho	ō	MD Prince George's	Laurel					1√XYes 2 □No
	28a	Director	10e. Street and Number	1	10f. Zip Code		1	0g. Citizen of What Co	ountry?
	h with	<u>=</u>	1130 12th Street		20707			U.S.A.	
36	within 72 hours after death with the Maryland ene. Than "natural", or Iteme 28a or 28a-f show the Medical Evaniner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes, Give Year or Dates:	No WWII	Was Decedent of His f Yes, specify Cuban 1 ☐ Yes 2 XXNo	panic Origin? (Spe i, Mexican, Puerto i Specify:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	
9	"natural",	ed	15. Decedent's Education	16a, Deced	tent's Usual Occupat	tion		16b. Kind of Business	/Industry
21215-0036	hin 72 n "n n	pie	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Give life. I	kind of work done du DO NOT use retired)	uring most of workii	19		
N	giene giene er the	Completed	Grade 10		ok Binder		J	Jnited Stat	es Governmen
pu	oe file la! Hy d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name		,	
yla	Men	ို	Dennia E. Merson			Lena B.		-	
Maryland	ges 1 and 2 should be filed within 72 ho to f Health and Mental Hygiene. : If item 27 le marked other than "natur or other traumatic event, It a Medical		19a. Informant's Name/Relationship (Type, Print)  Donna Carr / Personal Re		,			r, City or Town, State, . L, Maryland	•
<u>a</u>	s 1 and 2 of Health of item 27 I		20a. Method of Disposition	20b. Place of Dispo	sition (Name of			20c. Location - City or	
Baltimore,	permit. Pages of Department of himportant: if ite any injury or of once.		1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 14 ☐ Donation 5 ☐ Other (Specify)		natory or other place Cemetery	·		Laurel, Ma	
Ħ	permit. Pa Departmen Important: any injury pnce.		21. Signature of Funeral Service Licensee	1 -4				·	ir y rand
Ba	Departi Import any ir		1 GR S. C.	3 3	Name and Address Oonaldson 13 Talbot	t Avenue	Laurel	l, Maryland	
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li	d the death. Do not ent ne.	er the mode of dying	, such as cardiac o	r respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician		regulting in donth)	dial Infarc	tion				1 day
	/Medical Examiner		Due to (or as	a consequence of):					3.0
		- G		ry Artery D a consequence of):	lsease				10 years
	uted d ansit	E E	cause. Enter Underlying Cause (Disease or injury that initiated events  Type 2	diabetes					10 years
o,	icate be executed physician and the burial-transit	dical Examiner		a consequence of):					
68760,	ite be iysicia ne bu	cal	d						
	ng ph as th		IF FEMALE:						
P.O. Box	requires that the death certif een signed by the attending hould be detached for use as	by Physician/Me	23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	s that ned b e deta	y P	Part II. Other significant conditions contributing to death b	out not resulting in the u	nderlying cause giver	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Records,	w require been sig should b	edt	Congestive Heart Failure				1 🗆 Y	es 2□No 3□Pr	robably 4 🖾 🗷 nknown
000		Completed					24a. Was a	n 24b. Were at	utopsy findings available completion of cause of
Ä	sicien: The law certificate has t irector, page 2 s	E O					perform	med? death?	
Vital	entific octor,	Be (	25. Was case referred to medical examiner?			26. Place of Death	(Check only on	Θ)	
of V	Physicien: r this certific ral director,	P	1 ☐ Yes 2 📉 Xo Hospital: 1 ☐ Inpati	ent 2 ER/Outpatien		4   Nursing Hor		ence 6 Other (Spe	city)
n	0 0 0	lon;	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (Month, Da	y Year) 28b. Time of Injury	Work	at ? es 2 □No	88a. Describe no	ow injury occurred	
Division	Attending r death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of In	jury - At home, farm, str			28f. Location (Si	treet and Number or Ri	ural Route Number.
Di√	after after Dire	Certification;	4 Homicide determined 289. Place of in building, e	c. (Specify)	,, <del>-</del>		City or Tow	n. State)	
	To the Hospital or Attendin within 24 hours after death.  To the Funerel Director: Att completely filled in by the fun	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best 2 Medicel Examiner: On the basis of and manner st	if examination and/or in	n occurred at the time vestigation, in my opi	e, date and place, a inion, death occurre	and due to the c ed at the time, d	ause(s) and manner as ate and place, and due	s stated. a to the cause(s)
	To th Within To th	Me	29b. Signature and title of certifier		29c. License	number	2	9d. Date signed (Mont	th. Day, Year)
	101		) Paul M	-6	D 43	237		December	1, 2005
1	14		30. Name and address of person who completed cause of			a 1.		3	7 00707
Ģ	_			l Laurel Pa		Suite 102	2 Laure	eı, Marylar	na 20707
	Sta Registi		31. Date filed (Month, Day, Year) 32. Regist DEC 0 5 2005	rar's Signature	20				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Mohr 3:05 P M December 1,2005 Francis Lerov /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Co. Dundalk 2704 Gray Manor Court If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 1,1936 Birthplace (State or Foreign Country) **Funeral** Days Hours DOM 2 F Yrs. 213-32-7422 69 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or iteme 23a or 28e-f ehow 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State treumatic event, the Madical Examiner must be nutitive at 1 ☐ Yes 2 No Dundalk Director Baltimore Mary1and 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 21222 2704 Gray Manor Ct. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1√Xes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore Gas & Elementary/Secondary (0-12) College (1-4or 5+) Electric Co. Truck Driver 10 Years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jennie Mae Hoffmaster 2 Charles Carol Mohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2704 Gray Manor Ct. Dundalk, Maryland (Wife) Margie Anne Mohr other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Towson, Maryland Hilltop Service Corp. 12/3/2005 4 Donation 5 Dother (Specify) al Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of F 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, othern failure. List only one cause on each line. Immediate Cause (Final myseardial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner coronary arresy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical attending pt for use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 1 🗆 Yes P.O. ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Distretes milities 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown escenie cardioniza 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? page certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 2 ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; After 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide within 24 hours a To the Funarel I Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-28097 Pouged atterrases MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9114 Philadelphilia Food. Sutt 108, Baltemore ald, 21237 31. Date filed (Month, Day, Year) #32. Registrar's Signature State DEC 0 5 2005 Registrar

			For State	State of M			nent of F cate of	tealth and N	Mental Hy	4	UUJ.	39092
		*	Registrer  1. Decedent's Name (First, Middle	, Last)		Certine	Jale Of	Dealii	2. Date of D	Reg. N eath	0.	3. Time of Death
	Physici		Lewis Antonio N	Mitchell II	I				Month		ay Yea	ar link R.
	/Medic Examin		4a. Facility Name (If not institution	give street and number	r)	4b	City, Town, o	or Location of Death			c. County of D	
		The state of the s	ST. Agwes.	Hospital		1	ALTIN	none m	ARYLAN	0	N/A	
	. Funeral		5. Social Security Number	6. Sex 7. A	nge (In yrs. last bir 64	Mor	Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth ay, Yea	9.1	Birthplace (State or Foreign Country)
	Director		249-58-3322 Usual Residence of Decedent	122811 2	04	Yrs.			Dec. 2	9, 1	.940	Country) South Carolir
	land ow		10a. State 10b. County		10c. City, Tow	n or Location	1					10d. Inside City Limits
	Mary -f sh	tor	MD N,	'A			Balt	imore				1 X Yes 2 ☐ No
	h the	irec	10e. Street and Number			10	f. Zip Code			10g. C	itizen of What	Country?
	th wit	a D	3016 Walbrook A	Avenue			21	.216		Un	ited S	tates
	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23s or 28a-f show ant, I's Medical Exam actitual termillical in	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	-7	13. Was D	ecedent of H	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or N Rican, etc.)	0-	14. Race - A Black, W	merican Indian,
36	s afte		1 ☐ Never Married 2 🔀 Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 TYes 2 If Yes, Give	No 10-31-	61,00	es 21 No	Specify:			Specify:	
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<u>ya</u>		<sup>o</sup>	Lewis A, Mitche						Willie			
Maryland	2 short and is m		19a. Informant's Name/Relationsh			-		and Number or Ru				e, Zip Code)
	s 1 and 2 should of Health and Mer item 27 is marke other treumatic		Virginia Mitche 20a. Method of Disposition	ell Wife	20h. Place of	Disposition	(Name of	Ave., Bal	ltimore Date			or Town, State
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垂	iit. Partme	1	'4 Donation 5 ☐ Other (Sp. 21. Signature of Funeral Section 1)		Garri	ison F		12-7-				lls, MD
Ва	permit. Pages 1 Department of h Importent: If ite eny injury or ot		Canal Miss	200				<sup>ss of Facilit</sup> Ambi ds Ferry				
	® 4		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause	ed the death. Do						Owne, 1	Approximate
	Physician	Ì.	Immediate Cause (Final disease or condition	only one cause on each	L.,							Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or a	s a consequence	of):	5					30 minutes
,	Examiner		Sequentially list conditions.	b. —								
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fo√ 68760		edical	11.	u								
3 ×	death certifi e attending ed for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	e of pregnancy 2 Fetal death	3 □Eator	oio orogonou				23d. Date of	delivery
. B	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death		oic pregnancy or <i>(specify)</i>				Month	Day Year
2.0.	res that the de signed by the a be detached t	Phy	9 Unknown									
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	(*)		30. Name and address of person	who completed cause of	death (Item 23a)	ype, Print)	<b>1</b> 00	200136		]	HZT	4005
	7		Ruan }	M. EVAWOT	w ac	xx 4	Aton	Are B	Altim	Ne	MA	21229
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	Physici /Medic		1. Decedent's Name (First, Middle, Last) Anthony Mc	Neil		2. Date of Death	Ž6, 2ŎÖ5	3. Time of Death 11:20 A M	
	Examin		4a. Facility Name (If not institution, give si 2303 Maryland Avent		4b. City, Town, or Location of Dea Baltimore		4c. County of Death N/A		
	Funeral Director		5. Social Security Number  6. Sex  17-84-6972  Usual Residence of Decedent	M 2 F 7. Age (In yrs. last binthday)	If Under 1 Year If Under 24 Hr.  Months Days Hours Mir	Month, Day, Year	96.2 Ma	place (State or Foreign ntry) LFY (And	
	the Maryland	ector	Maryland 10b. County N/A		cation  MUPE  10f. Zip Code	100.0	itizen of What Cou	10d. Inside City Limits 1 IX Yes 2 □ No	
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	Sta	ate	31. Date filed (Month, Day, Year) DEC 0.5.201	32 Registrar's Signature	CARL D				

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		/Medic Examin		4a. Facility Name (If not institution, gr				4b. City, Town	, or Location of		DECEME	4c. County	of Death	
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Sala		r death	Funeral	11. Marital Status	Armed F	edent Ever in U	.S. 13. V	Vas Decedent of Yes, specify C	f Hispanic Ori uban, Mexicar	igin? (Speci n, Puerto Ri	ify Yes or No ican, etc.)		e - Ameri k, White	ican Indian, , etc.
expine	5-0036	72 hours afte natural', or li dical Evando	by	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, G Year or [	ve '		□Yes 21x1	lo Specify:			Specify	∘Whi	te
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3	-	1 and Healtl Sm 27 thar t		Donald E. Michae  20a. Method of Disposition	:1-husba	20b. F	Place of Dispo	Ridgefie sition (Name of		/,Lut		LIE, MD		093 own, State
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	rds,	w requires that been signed should be de	ed by								10	Yes 2 No	3 🗌 Pro	bably 4 🗍 Unknown
	of Vital Records,	: The law recate has be page 2 sho	Completed								24a. Was autor perfo 1 Yes	psy ormed?	prior to co death?	opsy findings available impletion of cause of
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	Div	tal or /	Certi	4 Homicide	build	ling, etc. (Speci	fy)				City or Tox	wn, State)		
		To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ext	miner: On the I	e best of my kno pasis of examina oner stated.	owledge, death ation and/or in	occurred at the restigation, in m	time, date an y opinion, dea	nd place, an ath occurred	nd due to the d at the time,	cause(s) and ma date and place,	inner as s and due t	stated. to the cause(s)
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Ira T. McDonald 05- 8023 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			For State Registrar	(	Certificate of Death	Reg.		39093					
	Physici		1. Decedent's Name (First, Middle, Last)  Ira T.	McDonald		2. Date of Death November	28, 2005	3. Time of Death 9:15 A м					
	/Medic Examin		4a. Facility Name (If not institution, give s 406 Viewfield Ave		4b. City, Town, or Location of Dea Salisbury		4c. County of Death						
	Funeral Director		202-27 0727	THE OTE   04	day) If Under 1 Year If Under 24 Hr. Months Days Hours Mir		9. Birthp 1984 West	lace (State or Foreign http:// Virginia					
	how		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town			1	0d. Inside City Limits					
:	28a-f	ector	MD Wicomico	o Salis	10f. Zip Code	100	Citizen of What Cour	1 No Yes 2 No					
3	23a or	ai Dir	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	venue	21804	_	U.S.A.	y.					
920	ors arrer dee	by Funeral Director	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue  1 ☐ Yes 2 No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify:						
Maryland 21215-0036	be liste within 7 z nous after deen with the maryland tal Hygiene. Ital Hygiene. d other then "neturel", or iteme 23a or 28a-f ehow event, the Modical Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	Colfege (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of wo life. DO NOT use retired) Never worked	orking 16b	N/A	dustry					
מ יי	be riled within ital Hygiene. id other then event, the Ma	Be	17. Father's Name (First, Middle, Last)			ame (First, Middle, Maid							
<u> </u>	marked	P	Ricky A.  19a. Informant's Name/Relationship (Tv	McDonald, Sr.	Mailing Address (Street and Number or F		Lawson ty or Town, State, Zip	Code)					
≅	and 2 s Belth ar n 27 is		Lillian Lawson– A	unt 11	1 Ellen Lane, Morga	antown, WV	26501						
nore	ages I int of H t: If iter y or oth		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	lemoval from State cemetery	Disposition (Name of crematory or other place)  ak Grove 12/		: Location - City or To rgantown,						
Baltimore,	permit. Prages 1 and 2 should by Department of Heelth and Menta important: If item 27 is marked eny injury or other treumatic evance.		21. Signature of Funeral Service Licens	1 - 2	22. Name and Address of Facility Ruck Towson Funera		1050 Yo	rk Road					
Ex pernoe	Chysicien and American as the burial-transit as the burial-transit	i Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, feading to immediate bases, Enter Underlying Cause (Disease or injury)	a									
Box	death cen e ettendin id for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	Live birth 2 Fetaf death 3 Ectopic pregnancy  Pregnant at time of death 5 Other (specify)								
<b>D</b> .	quires mat n signed b uld be dete	þ	Part II. Other significant conditions coa	ntributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobaca 1 ☐ Yes	co use contribute to the	ne cause of death? ably 4 Unknown					
Vital Records,	I ne law requires that the ele hes been signed by th page 2 should be deteche	Completed				24a. Was an autopsy performed	prior to cor death?	psy findings available inpfetion of cause of					
Vita	certific rector,	o Be (	25. Was case referred to medical examiner? 13∰Yes 2 □ No	Hospital:	Other	eath (Check only one)		at same					
ō	Affer 9	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury 28b. Ti	28c. Injury at Work?  1 Yes 2 X No	Home 5 Residence 28d. Describe how in 500 PC 28f. Location (Street		dself					
<u>S</u>	To the Hospital or Attendation of Attendation of the Funerel Director: completely filled in by the		4 Homicide determined  29a. Certifier 1 Certifying Phy	ce, and due to the cause	e(s) and mamper as si	Ares ated.							
	the Ho hin 24 t the Fu nptetely	Medical	(Check only 22Medical Exami	ner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occ	curred at the time, date	and pface, and due to	the cause(s)					
-	o o o o o	~	29b. Signature and title of certifier	onia-Polle	29c. License number 0.C.M.E.		pate signed (Month, rember 29,						
1	Sta		30. Name and address of person who co		ype Print) 11 Penn Street, Ba	ltimore, Ma	aryland 21	1201					

DHMH 17 Rev 1/2001

State

Registrar

DEC 0 5 2005

Physicia	an	1. Decedent's Name (First, Middle, Last)  RECRUA - MURTIN - MONCRIEFF	2. Oate of Death  OECEMBER 2, 2 Year 10 PA
/Medic Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  2111 Ganton Green Apt. 207 Marriottsville	4c. County of Death
ט		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Howard Marriottsville	10d. Inside City Limit 1 ☐ Yes 2 ☐ N
ath with the	۵	10e. Street and Number 2111 Ganton Green Apt. 207 21104	10g. Citizen of What Country? Canada
72 hours after death with the Maryland natural; or items 23s or 28s-f show dical Executive roust be notified at	by Fur	11. Marital Status  1 □ Never Married 2 ▼ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ▼ No Specify:  13. Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto Forces)  14. Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto Forces)  15. Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto Forces)  16. Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto Forces)  17. Was Decedent of Hispanic Origin? (Specify: If Yes, specify Cuban, Mexican, Puerto Forces)	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
within ane. then "	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Diesel Mechanic	16b. Kind of Business/Industry  Tractor (John Deere)
should be filed ind Mental Hygis marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last)  Aurthur Oswald  18. Mother's Name  Evelyn  19a. Informant's Name/Relationship (Type, Print) (Spouse) 19b. Mailing Address (Street and Number or Rural	
jes 1 and 2 sk of Health and If item 27 Is n or other traun		Mrs. Clare Dorothy Moncrieff 2111 Ganton Green #207	Marriottsville, MD 21104  Date 20c. Location - City or Town, State
permit. Pages 1 and Department of Healt Importent: If item 2 any injury or other once.		`4 □Donation T5 □Other (Specify) All County Cremation 12/5/2	2005 Sykesville, MD E & CHAPEL, PA (Box 195) 84 (410)-795-1400
Independent of the project of the pr	I Examiner	23a. Part in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  CARDID MD DATHY  Oue to (or as a consequence of):  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	or respiratory arrest, Approximate Interval Between Onset and Death
that the death certificate bed by the attending physic detached for use as the b	hysician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23d. Date of delivery Month Day Year
e law requires has been sign je 2 should be	Completed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  CARCINUMA UF TITE PRUSTATE	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknow  24a. Was an autopsy performed? performed? 1 Yes 2 No 1 Yes 2 No
anding Physician: nath. or: After this certifica	Certification; To Be C	1	h (Check only one)
To the Hospital or Atti within 24 hours after de To the Funeral Direct completely filled in by ti	Medical Cert	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and place, a control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at the time, date and the control of my knowledge, death occurred at t	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SCUTT MAUREL MD 2465 (POUTE 97 SUITE	VECKINDEL C, LOU

			1- State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death	Mental Hyo	giene () ()	15	39097
ı	Physici /Medio		1. Decedent's Name (First, Middle, Last) Emily Louise Novak	2. Date of Dea Month Novembe	Day	Year 05	3. Time of Death 6:55а м
	Examin		4a. Facility Name (If not institution, give street and number)  Chapel Hill Nursing Home  4b. City, Town, or Location of Deat Randallstown	h	4c. County Balt:		
	Funeral Director		$\begin{array}{c ccccccccccccccccccccccccccccccccccc$		(, Year)	9. Birth Cou	plece (State or Foreign ntry)
	•how	or	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location           Md         Baltimore         Woodstock				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	a or 28e-1	i Director	10e. Street and Number 10f. Zip Code 21163		10g. Citizen of V	Vhat Cou	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Plygene. Importent: If Item 27 is marked other then "naturel", or Items 23e or 28e-f ehow entry injury or other treumatic event, the Medical Examinar mastice notified at once.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:	Specify Yes or No- to Rican, etc.)	Blac	e - Ameri k, White	
Maryland 21215-0036	ithin 72 hour 18. 18n "naturel 1 Medical E.	Completed t	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	rking	16b. Kind of Bu		ndustry
nd 21	al Hygier Jother th	Be Cor		me (First, Middle,			
aryla	should to	P.	Jacob John Strehle Elsie  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or R	Louise T		State, Zi	p Code)
	of Heelth of Hem 27 is		Dorothy Hunter (niece) 10608 St. Paul Ave.,  20a. Method of Disposition (Name of cemetery, crematory or other place)	Woodstoc Date	k, Md 21		own, State
Baltimore,	nit. Page artment o ortent: If injury or It.		Woodlawn Cemetery 11-2		Baltimor		
Ba	Deport		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Ha  P.O. Box 195 Syke  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia	sville,	Md 2178	ne &	Approximate
100	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  List only one cause on each line.  List only one cause on each line.  List only one cause on each line.  List only one cause on each line.  List only one cause on each line.  List only one cause on each line.  Due to (or as a consequence of):	c or respiratory ar	1651,		Interval Between Onset and Death
	Examiner	iner	Sequentially list conditions, if any, heading to immediate cause. Enter Underlying Cause (Disease or injury				
8760,	cate be executed physicien and the burial-transit	dicai Examin	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
.O. Box 68	ne death certifi the attending thed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Dat Moi	e of deliv	rery Day Year
Δ.	sign sign d be	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		obacco use conti res 2 No	ribute to 3 ☐ Pro	the cause of death?
Division of Vital Records,	The ete h page	Completed			rmed?	Vere autorior to colleath?	opsy findings available ompletion of cause of
Vita	ysic is ce direc	o Be	examiner? Hospital:	ath <i>Check only o</i>	THE PARTY	ər (Speci	fy)
ion o	To the Hospital or Attending Phys within 24 hours effer death. To the Funerel Director: Affer this completely filled in by the funeral di	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe h	ow injury occurr	ed	
Divis	al or Atta s efter de if Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Ton		er or Rur	al Route Number,
	e Hoepital	edicai (	29a. Certifier (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one)  Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place (Check only one)	e, and due to the ourred at the time, o	cause(s) and ma date and place,	nner as	stated. to the cause(s)
)	To the within 2. To the complet	W	29b. Signature and title of certifier  M. Shahnah MD  29c. License number  D006353	11	Voven		
			M. Shakhar MD DOOG 323  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Mandana Shahbar 25 Main Str S  31. Data filed (Mosth Day, York)  32. Replictant's Signature	te#200	RE, N	1D &	21136
19.	St. Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature				

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H			giene	5 39098
			Decedent's Name (First, Middle, Las	t)				2. Date of De	ath	3. Time of Death
	Physici		Pamela		Newman			Decembe	er 2 20	0057 M
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	I C WILLIE	4b. City, Town, or	Location of E		4c. County	
	CXAIIIII	е	St. Agnes Hospit	al		Baltime	ore			
	Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday)	If Under 1 Year	If Under 24		th	9. Birthplace (State or Foreign
	Director		217-64-5321	□M 2\\ F	49 Yrs.	Months Days	Hours	Min. (Month, Da Aug 31		Washington DC
			Usual Residence of Decedent			· · · · · · · · · · · · · · · · · · ·				
	ehow		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Ma Ma	cto	MD		E	altimore				1 ☐ Yes 2 🔀 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?
	23a		901 Not	tingham Ro	ad Apt4B	2122	9		U.S	.A.
	dea me me	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin In, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	14. Race Black	e - American Indian, ck, White, etc.
98	72 hours efter death with the Maryland natural; or Items 23a or 28e-f ehow Jisal Examinat must be notified at		1 Never Married 2 Married	1 ☐ Yes 2 🔀 N If Yes, Give		1 ☐ Yes 20 No			Specify	
8	ural',	q p	3 ☐ Widowed 4 ☑ Divorced	Year or Dates:					1	Black
7	nat nat	Completed by	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	durina most oi	f working	16b. Kind of Bu	isiness/Industry
12	Mithig	ם	Elementary/Secondary (0-12)	College (1-4or 5	i+)				N	.d
22	filed within Hygiene. wher then "		12 17. Father's Name (First, Middle, Last)		Re	gistered		Name (First, Middle	Nurs Maiden Surname	
⊆	d a b ≥	Be	Thomas Newm					Verdella	Jones	-7
Ž	should nd Men marke	ပ	19a. Informant's Name/Relationship (	The state of the s	19h Mail	nn Address (Street :		or Rural Route Numb		State Zin Code)
Ma	d 2 s th an 7 is t		Monique R. Newman			Pelham Av		Baltimore		
	1 and Heelth em 27 Ither tr		20a. Method of Disposition	n Daugnee	20b. Place of Disp	osition (Name of	- 1	Date		City or Town, State
Baltimore,	Pages nent of h ant: If its ary or of		1 ☐ Burial 2次 ☐ Cremation 3 ☐		1	matory or other plac		0.15.105		
菲			4 □Donation 5 □Other (Specify 21. Signature of Funeral Service Licen					11824 Rei		ad, Maryland
Ba	permit. Departr Importa eny inji	Ŋ,	143	-				TE Reiste		
			23a, Part1. Enter the disease, or com	plications that caused						Approximate
			shock, or heart failure. List only	one cause on each lin	ne.	ſ	13	Λ		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. toel	dela	Kunoner	3 6 M	noohy		
	Examiner			Due to (or as	a consequence of):	7	1			
		_	Sequentially list conditions,	b. Due to (or as	a onsequence of):	Mond	0025	7		
~	pet nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
<	xecu al-tra	хаг	that initiated events resulting in death) Last	c Due to (or as	a consequence of):					
8760,	requires that the death certificate be executed een signed by the attending physicien and hould be deteched for use as the burial-transit		l	-						
687	phys phys	Physician/Medical		d						
Box (	leath certifica attending ph I for use as th	Z/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date	te of delivery
	atter for u	clar	in the past 12 months?	1□Live birth 4□Pregnant at		⊒Ectopic pregnancy ⊒ Other (s <i>pecify)</i>			Mor	nth Day Year
P.O.	that the de led by the a deteched t	ıysı	1 ☐ Yes 2 De No 9 ☐ Unknown	9□ Unknown						
	that ned b		Part II. Dther significant conditions of	ontributing to death b	ut not resulting in the	underlying cause give	en in Part I.	23e. Did	tobacco use contr	nbute to the cause of death?
ds	w requires that been signed to should be dete	d by						10	Yes 2 □ No	3 Probably Unknown
00	- C	Completed						24a. Was	an 24b. V	Were autopsy findings available prior to completion of cause of
Re	e la has	m							ormed?	death?
ā	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical				26 Place of	Death (Check only		Yes 2 No
5	Physician: this certific ral director,	00	examiner? N⊒Yes 2□ No	Hospital:	ent 2XXER/Outpatie	nt 3 DOA Oth		ing Home 5 ☐ Res		er (Snecify)
ō	Phys or this aral did	7: To	27. Manner of Death	28a. Date of Inju	ry 28b. Time o				how injury occurre	
Division of Vital Records,	Attending r death. ector: After by the fune	ig i	t Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury		k? Yes 2∐No			
Vis	Atter r des ector by the	HC	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of inj	ury - At home, farm, si	reet, factory, office		28f. Location ( City or To		er or Rural Route Number,
Ö	afte Dird d in b	Certification:	4   Hornicide	building, et	c. (Specify)			City of 10	WII, SIZIE)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Ph	ysicien: To the best	of my knowledge, dea	th occurred at the tin	ne, date and p	place, and due to the	cause(s) and ma	inner as stated,
	n 24 n 24 he Fu	edical	(Check out) 2 Medical Exer	niner: On the basis o and manner st	r exa <i>m</i> ination and/or ii ated.	nvestigation, in my o	pinion, death	occurred at the time,	date and place, a	and due to the cause(s)
	To the H within 24 To the F complete	ž	29b. Signature and little of certifier	1	. ^	29c. Licens	e number		29d. Date signed	d (Month, Day, Year)
			1 land	bell	( )	OCM	Œ	1	December	, 2, 2005
-	1		30. Name and address of person who	completed cause of	eath (Item 23a) (Type	, Print)				
	./		J. LA!LON LOC	KE WY	)	111 Pe	nn Str	eet Balt	imore, Ma	aryland 21201
		ate	31. Date filed (Month, Day, Year)	R.S	ar's Signature	all D			-	
	Regist	rar	DEC 0 5 200	15 The war	, St. Agent					

Decoder's Name (First, Middle, Last)   Decoder's Name (First, Middle, Majeder Surame)   Decoder's Name (First, Middle, Last)   Decoder's Name (First, Middle, Majeder Surame)   Decoder's Name (First, Middle, Last)   Decoder's Name (First, Middle, Last)   Decoder's Name (First, Middle, Majeder Surame)   Decoder's Name (First, Middle, Last)   Decoder's Name (First, Middle, Last)   Decoder's Name (First, Middle, Majeder Surame)   Decoder's Name (First, Middle, Last)   Decoder's Name (First, Middle, Majeder Surame)   Decoder's Name (First, Middle, Majeder Suram			1	State of Maryland / Department of Health a  1 - State Registrer Certificate of Death		tal Hygier	4000	39099
Examined  Examin		<b>域</b>					Day	3. Time of Death
Security of Power Security Running and Security Running Control (Centre)    Security of Power Security Running Control (Centre)			_	42 d -				X 11466 M
Northwest Hospital Center   Randal Stown   Baltimore   Special Center   Randal Stown   Baltimore   Special Center   Randal Stown   Special Center   Randal Stown   Special Center   Randal Stown   Special Center   Randal Stown   Ra	4							
Social Security Number   Color   Col		LAdilliii		Northwest Hospital Center Randallstown	n .		Baltimo	re
The state of the s	- 3	Funeral	12	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year II Under		Date of Birth	9. Bir	thplace (State or Foreign
The State of December 1 to State of December		-		THE PARTY OF THE P			934 Ma	
The content of the		D		Usual Residence of Decedent				Table 11 and 11 a
The content of the		how		10a. State 10b. County 10c. City, Town or Location				
The content of the		e Ma	cto	MO Butiness Woodlawn				TO THE ZYING
The content of the		or 28	lre.	10e. Street and Number 10f. Zip Code		10g.	Citizen of What C	ountry?
The content of the		th wi		17 Beacon H-11 ROOD 2120)				
Clarence T. Willis  See Manifestal Control (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19a. Manifestal Capacity (Type, Print)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  20b. Research (Dyne)  20b. Resea		eme erme	ne	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Orie	rigin? (Specify in, Puerto Rica	Yes or No- n, etc.)		
Clarence T. Willis  See Manifestal Control (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19a. Manifestal Capacity (Type, Print)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  20b. Research (Dyne)  20b. Resea	õ	or it		If Yes Give 1 1 Yes 2XI No Specify:	:		Specify:	
Clarence T. Willis  See Manifestal Control (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19a. Manifestal Capacity (Type, Print)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  20b. Research (Dyne)  20b. Resea	ğ	ural',	q p	3 Widowed 4 Divorced Year or Dates:				
Clarence T. Willis  See Manifestal Control (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19a. Manifestal Capacity (Type, Print)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  20b. Research (Dyne)  20b. Resea	ភ	72 h	ete	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most	st of working	160	. Kind of Business	Vindustry
Clarence T. Willis  See Manifestal Control (Type, Print)  19a. Informant's Name/Relationship (Type, Print)  19a. Manifestal Capacity (Type, Print)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  19b. Mailing Address (Sizeet and Number or Paul Route Number (Dyne Typen)  20b. Research (Dyne)  20b. Resea	N	Mithin ne.	d E	Elementary/Secondary (0-12) College (1-40r 5+)		NT - A	nd 1 Od	
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Physician / Mary Janu 23a Parti. Enter thy disease, or complications that dawed the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physicians and Cause (Final Physicians as consequence of):    Physician / Middlical Examiner   Mary Janu 23a Parti. Enter thy disease, or complications that dawed the dath. Do not enter the mode of dying, such as cardiac or respiratory arrest. Immediate Cause (Final Physicians as consequence of):	ğ	in it		1 & Buria: 2 Cremation 3 Premoval from State			ŕ	
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Physician (Medical Examiner)    Part III Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		40.200						
Due to (or as a consequence of):    Sequentially list conditions   Sequentially list conditio				shock, or hearf failure. List only one cause on each line.	s cardiac or res	spiratory arrest,		Interval Between Onset and Death
Sequentially list conditions.    Sequentially list conditions.   Service and programs   Sequentially list conditions.   Sequen				disease or condition	Lung	Dise	-5 -4	
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FFMALE   230. Was decoded to pregnancy   1   Live bith   2   Fetal death   3   Ectopic pregnancy   1   Live bith   2   Fetal death   3   Ectopic pregnancy   1   Live bith   2   Fetal death   3   Ectopic pregnancy   1   Live bith   2   Fetal death   3   Ectopic pregnancy   1   Live bith   2   Fetal death   3   Ectopic pregnancy   1   Live bith   2   Fetal death   3   Ectopic pregnancy   1   Live bith   2   Fetal death   3   Ectopic pregnancy   1   Live bith   2   Live bith	9	be e sician buria	a E					
Spoop of the state of the sta	28		ggc	d				
Spoop of the state of the sta	×	certif rding ise a	/W				23d. Date of de	alivery
Spoop of the state of the sta	ň	atter atter for L	clar	in the past 12 months?			Month	Day Year
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25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   26. Place of Death (Check only one)    26. Place of Death (Check only one)    27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)    28. Date of Injury   28. Time of Injury   28. Date of	g	uires sign ld be				1 🗆 Yes	2 No 3 P	robably 4 Dunknown
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   26. Place of Death (Check only one)    26. Place of Death (Check only one)    27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)    28. Date of Injury   28. Time of Injury   28. Date of	Ö	w req beer shou	ete			24a. Was an	24b. Were a	utonsy lindings available
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:   26. Place of Death (Check only one)    26. Place of Death (Check only one)    27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)    28. Date of Injury   28. Time of Injury   28. Date of	Ř	has ge 2	E G			autopsy performed	prior to death?	completion of cause of
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  31 Date filled (Month, Day, Year)  32cRegistrar's Signature	<u>a</u>			Of Was are intered to marked			No 1 □ Ye	s 2/2 No
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  31 Date filled (Month, Day, Year)  32cRegistrar's Signature	S	deat deat ctor: y the	lica	2 Account		Location (Street	t and Number or F	Tural Route Number,
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title ol certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32 Pegistrar's Signature	<u>S</u>	ior A after Dire	erti	4 Homicide building, etc. (Specify)		City or Town, Si	tate)	
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Date filled (Month, Day, Year)  32/Registrar's Signature		spita ours serai	0	29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time. date an	ind place, and	due to the cause	e(s) and manner a	s stated.
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  A 4 5 Completed cause of death (Item 23a) (Type, Print)  31 Date filed (Month, Day, Year)  32/Registrar's Signature		within of the omple	₹	29b. Signature and title of certifier 29c. License number		29d.	Date signed (Mon	th, Day, Year)
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in I can J. Charles 2 5310 C to Caurt Rang 21155		2			2	IJ e	CENA	2 7 7002
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Registrar BEC 0 5 2005 Report August 1997		Str	ite	31 Date filed (Month, Day, Year) 32/Registrar's Signature	0.4		10 K 20 M 10 M	
	3			DEC 0 5 2005 A				

			For State Registrar	State of Ma	aryland		irtment of F tificate of				giene Reg. No.	05	39100
i i	Physicia		1. Decedent's Name (First, Middle, Las Augusta-An		01s	en				2. Date of Dea Month ecentb	Day	Year L. 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give Saint Joseph	street and number)			4b. City, Town, o				· ·	County of Dea	
	Funeral Director		274-44-0220	TH OFF	e (In yrs. Ia 83	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	B. Date of Birth (Month, Day eb. 9	h V. Year) 1922	C	thplace (State or Foreign buntry) Shington DC
	aryland show dat	_	Usual Residence of Decedent  10a. State 10b. County			Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	he Ma	Director	Md. Baltimor	e	Tows	on	10f. Zip Code				10g Citiz	en of What Co	
	with 1		800 Southerl	v Rd #180	8		212	286			rog. Onz	US	
	death me 23	Funeral	11. Marital Status	12. Was Decedent		i. 13. V	Vas Decedent of H		rigin? (Speci	ify Yes or No-	. 1	4. Race - Am	encan Indian,
036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 ie marked other than "naturet", or iteme 23a or 28a-f ehow other traumatic event, its Mudical Examinat main the myllfied at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ Yes If Yes, Give Year or Dates:	No		Yes, specify Cub	an, mexicai Specify:		ican, etc.)		Black, Whi Specify:	White
2-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	ducation de completed)		(Give	lent's Usual Occup kind of work done	durina mos	st of working	7	16b. Kin	d of Business	/Industry
2121	d within giene. er then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)		emaker	a) 			Own	n Home	
Maryland 21215-0036	uld be file Aental Hy rked oth	To Be (	17. Father's Name (First, Middle, Last)  Joseph Morgan							First, Middle, h Cr			
Mary	12 should hand hand here	Q 8	19a. Informant's Name/Relationship (				g Address (Street Sotherly						
ē,	Healt Ham 2	1	20a. Method of Disposition	17 Husband	20b. Pla	ace of Dispo	sition (Name of natory or other place		71000 Da		•	ation - City or	
Baltimore,	Pages ment of ant: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification )		1		Service C	· 1	2-3-0	5	Tows	on, Md.	
Balt	permit. Pages 1 and Department of Healti Important: If Itam 2; eny injury or other t once.		21. Signature of Funeral Service Licer	ISEE		22	Name and Addre Ruck Tow 1050 Yor	ss of Facili Son F k Rd.	unera Tows	1 Home on, Md	, Inc	204	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused one cause on each li	the death. ne.	Do not ente	er the mode of dyir	ng, such as	s cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
) (2) (3)	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Respir			lure						
	Examiner			Due to (or as		ence or):							
	D :	ner	Sequentially list conditions, if any, leading to intrinducto cause. Enter Underlying	Due to (or as	a conseque	erice of):		-					
oʻ	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):		_					
8760,	cate be physicials the bu	dlcal		d									
P.O. Box 6	that the death certifica ed by the attending ph detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pregnancy	y			23	3d. Date of de Month	liwery Day Year
Ś	uires that t signed by id be detai	P	Part II. Other significent conditions of URINARY TRACT		ut not resul	lting in the ur	nderlying cause giv	en in Part I	I,	23 <i>e</i> . Did to	1		o the cause of death?
Division of Vital Record	Physician: The law requires that the rthis certificate has been signed by th rail director, page 2 should be detach	Completed	ATRIAL FIBRIL	LATION								24b. Were a prior to death?	utopsy findings available completion of cause of
ital	ertifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place	e of Death (	Check only o		10.100	
of <	Physician: this certificaral director, p	P	1 ☐ Yes 2 No	Hospital: 1 A Inpatie	_	R/Outpatien	1 3L DOA					Other (Spe	ocify)
ono	Attending For death.	tlon:	27. Magner of Wath  1 Natural 5 Pending 2 Accident investigation	28a. Dite of Inju (Month, Da	y Year)	28b. Time of Injury	Wo	ryat rk? ∣Yes 2. [		ld. Describe h	iow injury	occurred	
Divisi	al or Atter s after dea i Director d in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inj building, et	ury - At hon c. (Specify)	ne, farm, str	eet, factory, office		28	Bf. Location (S City or Tow		Number or R	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)  1X Certifying Physics Certifying Phys	nysicien: To the best niner: On the basis o and manner st	f examination	vledge, death on and/or inv	occurred at the tile vestigation, in my o	me, date ar opinion, dea	nd place, an ath occurred	d due to the o	cause(s) a date and p	and manner a place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	1 .	$\supset$	MY	29c. Licens	se number		:		signed (Mon	
)	2		1 Sichard	Lutt	reuv	00-1-7		1826			12	- (-0	5
1	2		30. Name and address of person who Richard Linith			-	Print) Osler I	)rive	а Там	son.	Mari	land	21204
*	Sta Registr	-	31. Date filed (Month, Day, Year)  BEC 0 5 20	32 Registr	ar's Signati	ure	a de la companya della companya della companya de la companya della  - on V to	- 1 W 47	no ser i i ii		year man t 6 book	and the second of the second o	

			For State Registrar	State of Ma	arylan		rtment of H	lealth and M		giene ()	5 3	39101	
			Decedent's Name (First, Middle, La.	st)					2. Date of Dea	ath		3. Time of Death	
	Physicia /Medic			EDV	VARD	PE	REZ		Month //-	30 -	Year C5	9:05 am	
	Examin		4a. Facility Name (If not institution, give	e street and number)			<u> </u>	or Location of Death		4c. County			
			Franklin Square	1.02	Cenk		Koseda If Under 1 Year		2 Date of Bird	Bal			
	Funeral Director		5. Social Security Number 6. S 158-12-3195	ex MCXM 2□F 7. Ag	9 4	last birthday) _ Yrs.	Months Days		8. Date of Birti (Month, Da)	-1911	Cour	place (State or Foreign ptry) CUBA	
			Usual Residence of Decedent						07 00	1911			
	ırylan show	_	10a. State 10b. County	IMODE	10c. Cit	y, Town or Loc			VED		1	0d. Inside City Limits	
	ith the Marylar or 28e-1 ehow	Director		IMORE				DDLE RI	VER	10- 02 /11		1 ☐ Yes 2 <b>X</b> ☐XNo	
	with the		10e. Street and Number 1800 OLD EAS	STERN A	ENU	F	10f. Zip Code	221		10g. Citizen of W	S.	A.	
	ns 23	Funerai	11. Marital Status	12. Was Decedent	Ever in U.		1	Hispanic Origin? (Spo pan, Mexican, Puerto	ecify Yes or No-		- Americ	an Indian,	
9	after or Itel	Fur	1 Never Married XXMarried	Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give	<b>(</b> 10		Yes, specify Cub □ <b>X</b> Yes 2□ No		Hican, etc.)	Specify:	c, White, Ա L	etc. ITE	
003	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow the Medical Examiner must be rollified at	d by	3 Widowed 4 Divorced	Year or Dates:									
	"nati	iete	15. Decedent's Education (Specify only highest gradual)	ducation ade completed)		(Give k	ent's Usual Occup ind of work done O NOT use retire	during most of work	ing	16b. Kind of Bu			
دعمرا 1 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23e or 28e-1 ehov eny injury or other treumetic event. The Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		MANAGE	*		DEPART	MENT	STORE	
o bu	e filed al Hyg I othe vent,	Be C	17. Father's Name (First, Middle, Last,		250			18. Mother's Name			9)		
$\mathcal{E}d\iota$ aryland	ould b	To		DUARDO	PER			MAR		AIS		22002	
Z) Mar	d 2 sh th and 7 is rr treum		19a. Informant's Name/Relationship (					t and Number or Rura PINF TRA		-		BEACH, FL.	
	Heal Heal tem 2		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. F	lace of Dispos	ition (Name of	1 .	Date	20c. Location -			
Pere altimore	Pages ent of nt: If i		XX Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif				atory`or other pla GE MEM.P		5-2005	ELKRIDG	E,MA	RYLAND	
altii	permit. Departm importe eny inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  1050 YORK ROAD										
<u>a</u>	89 1 2 8		R. J. Kins		G.RU7			N FUNERAL			SON,	MD.21204	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	d the deat ne.	h. Do not ente	r the mode of dyi	ing, such as cardiac (	or respiratory ar	rest,		Approximate Interval 8etween Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Lac	tic		GiS						
	Examiner			C 106	a conseq	uence of):	2 fac	ile Col	h's				
1	Α.	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a conseq	uence of):	1 140	THE COL					
	be executed ician and burial-transit	Examiner	that initiated events	C									
,00	ate be execu physician and the burial-tra		resulting in death) Last	Due to (or as	a conseq	uence of):							
09/8	cate b	dicai	•	d									
9 ×	death certifica attending pt d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Date	of delive	Brv	
Вох	death a atter d for L	iciar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a			Ectopic pregnanc Other (specify) _	:у 		Mor		Day Year	
P.O.	that the death ed by the atte detached for	hys	9 Unknown	9□ Unknown									
	w requires that the death certificate be to be signed by the attending physicis should be detached for use as the bur	by	Part II. Other significant conditions	contributing to death t	ut not res	ulting in the un	derlying cause gr	ven in Part I.		0/		ne cause of death?	
ord	requii een s hould	eted	- Lypny sema	. >					1 🗆 Y				
3ec	> 0	Completed	Coronary H	eart Dise	65C				24a. Was autop	sy p	/ere auto fior to co eath?	psy findings available mpletion of cause of	
<u>=</u>			25. Was case referred to medical					00.01(0	1 ☐ Yes	21140 1	□Yes	2 No	
₹	s certi	o Be	examiner?	Hospital: 1 []Impati	ent 2	ER/Outpatient	3□ DOA Ott	26. Place of Death her: 4 □ Nursing Ho		ne) lence 6 ⊡Othe	r (Specif	ν)	
٥	g Phy ler this neral c	n: T	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of Injury	28c. Inju			ow injury occurre	1	,,	
io	endin sath. or: Aff he fur	atio	1 Natural 5 Pending 2 Accident investigatio	n	, ,	,,		Yes 2□No					
Division of Vital Records,	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific: completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined		jury - At he tc. <i>(Specif</i>	ome, farm, stre y)	et, factory, office		28f. Location (S City or Tow	Street and Numbe m, State)	er or Rura	l Route Number,	
	spitel ours a nerel E		29a. Certifier 1 Certifying Pl	nysician: To the best	of my kno	wledge, death	occurred at the ti	ime, date and place.	and due to the	cause(s) and mai	ner as s	ated.	
	ne Hos ne Fur stetely	Medicai		miner: On the basis of	of examina	tion and/or inv	estigation, in my	opinion, death occur	ed at the time,	date and place, a	nd due to	the cause(s)	
	To th withir To th	M	29b. Signature and title of certifier	A.			29c. Licen	se number		29d. Date signed	(Month,	Day, Year)	
	0		) In	Thenda	<u> </u>			1184	6	11/30/	105		
1	50		30. Name and address of person who	completed cause of	death (Iter	n 23a) (Type, F	Print)	se number  21 84  Buare Dri	11. A.	11:	111.	7/207	
6	Sta	ato.	31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture &	184139	icare Di	ve pai	Marie,	MO C	163/	
	Regist		DEC 0 = 200	5 Roman	S AND S	See all the see	All Parks						

State of Maryland / Department of Health and Mental Hygiene 005 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician PUMPHRE WAYNE 0313AM DECEMBER 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HEALTHCARY BALDMORE SAINT AGNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F 66 Yrs. September 13, 1939 220-36-4744 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r then "natural", or Iteme 23s or 28e-f show the Medical Examinar roust be notified at Baltimore 1 Yes 2 No Lansdowne Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 2200 Smith Avenue 21227 Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes. Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: UNK Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dairy Factory Manufacturer 12 ages 1 and 2 should be filed vent of Health and Mental Hygie t: If item 27 is marked other if yo or other treumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Thomas Octavius Pumphrey Deloras Vernal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Upton Pumphrey / Brother 1889 Lakeland Drive Finksburg, MD 21048 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of I 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Importent: If any injury or once. 12/02/05 Anatomy Gifts Registry, Inc. Hangver, 4. ■Donation 5 Other (Specify) 21. Signature of Juneral Service Ilcensee 22. Name and Address of Facility SU ANMONY GIFTS MEGISTRY 7522 CONDELLEY DR, HANDLYR MYD 21076 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Renal Concel 4 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ned by the attending physician and detached for use as the buriat-transit Due to (or as a consequence of): Physician/Medical Box 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 24a. Was an page 2 s has autopsy performed certificate 1□ Yes 2☑No Vital After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA ot 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1. □ Natural 1 ☐ Yes 2 ☐ No death Director: / 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A 524385 2835 28 = combox 2 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RALMMORE MD 21229 A KARRAS M.Z 900 Caken AVE 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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PUMPHARTY

			State of Maryland / Dep  1- State Registrar Ce	artment of Health and Nertificate of Death	Mental Hygier	6007	39103
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physic		GEORGE HERBERT RO	ANE	11/	27 2005	645-PM
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	NOV CITIOEF	4c. County of Death	0 1
	Exami	iei	Future Care Sandtown Winchester	Baltimore		NA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthpl	lace (State or Foreign
	Director		281-12-9350 12M 20F \$5 Yrs.	Months Days Hours Min.	(Month, Day, Yea	ar) Coun	3GINIA
			Usual Residence of Decedent		101.10,11	W ///	3770774
	yland		10a. State 10b. County 10c. City, Town or L	ocation		10	Od. Inside City Limits
	Mar First	ţ	MARWAND N/A	BALTIMORE	E CITY	1	1 XYes 2 No
	1 the	Director	10e. Street and Number	10f. Zip Code		Citizen of What Coun	try?
2	38 o		1000 N. GILMORE STREET	1 212	17	11.5A	_
oah	1036  ours after death with the Marylar rel', or Items 23e or 28a-f show	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - America	
~§ .	after after	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗷 No	If Yes, specify Cuban, Mexican, Puerto	Hican, etc.)	Black, White, e	etc.
1	Ones on the control of the control o	by	3 ☐ Widowed 4 🙀 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 Ø No Specify:		Specify: 32	ACK
0	21215-0036  d within 72 hours aff giene. ref then "neturel", or the Medical Every	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	edent's Usual Occupation  e kind of work done during most of work	16b.	Kind of Business/Ind	lustry
8	Man	]dc	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	ing	_	
neorge	Z giện đị	lo C	10 HIGRADE	1EAT CUTT	ER	5	
CF	ING 21215-0036  be filed within 72 hours after death with the Maryland tal Hygiene. d other then "neturel", or Items 23e or 28e-f show event, the Medical Evertiret must be retified at	Be (	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	len Sumame)	1
	Vial by Wild by Ments with the distriction of the contract of	2	HENRY ROANE	SUE	1	LEWMA	HN
	Maryland of 2 should be file lith and Mental Hy 27 Is marked oth traumatic event		19a. Informant's Name Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rui	ral Route Number, Cit	y or Town, State, Zip	Code)
			WANDA HOPKINS (NIECE) 218.	83 HICKORY DR.	GEORGETO	WN. DE.	19947
	Baltimore, bermit. Pages 1 ar Department of Hea mportant: If item in injury or other		20a. Method of Disposition 20b. Place of Disposition cemetery, cre	osition (Name of / / / / / / / / / / / / / / / / / /		Location - City or To	wn, State
	Page ent c nt: If				12-05 B	ALTIMUR.	EMA
	Balti permit.   Departm Importa any inju		21. Signature of Funeral Service Licensee	N PARK CEME 12-0 2. Name and Address of Facility 2	140 N. FUI	tON AVEDU	e MA 2/2/7
	Dan Permil Depar Impo			oseph H. Brown J.	r. Funeral	1 Home 13	altimore
			23a, Part1, Enter the disease, or complications that caused the death. Do not en				Approximate Interval Between
	20.00		shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death
	Physician /Medical		disease or condition a. TROS1 177 &	CANCER			
	Examiner		Due to (or as a consequence of):				
		<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	pel jist	ij	if any, leading to immediate cause. Enter Underlying Cause (Loses or Frjury that initiated events c.				
	xecul and	Examiner	that initiated events resulting in death) Last  C				
	18760, cate be executed physician and the burial-transit						
	87 cate	dicai	d				
	<b>9</b> ∰ ∑ %	a)	IF FEMALE: 23c. If yes, outcome of pregnancy				
	BO ath c	an	in the past 12 months?	□Ectopic pregnancy		23d. Date of deliver Month	ry Day Year
	the a	sic	1 Yes 2 No 9 Unknown 9 Unknown	Other (specify)			•
	P,O. that the de ed by the detached	by Physician/M	Part II. Other significent conditions contributing to death but not resulting in the	underhing cause given in Rest I	22a Did tobaco	o use contribute to the	o cause of death?
	dS, F	by	TYPERTENSIVE CAPDIONS WAS			2 □ No 3 □ Proba	
	cord  * require been sis	ted	MYTELIEDNUE EMPIONS CONTAIN	- 2126428	T Tes	2   100 3   100 2	tbly 4 Conknown
	0 8 S S	Completed			24a. Was an autopsy	24b. Were autop	osy findings available appletion of cause of
	The I	No.			performed?	? death?	
	Vital F icien: Th certificate	a)	25. Was case referred to medical	26. Place of Dea	th (Check only one)		
	f V ysic is ca direc	To B	examiner?  1   Yes 2   SNo   Hospital: 1   Inpatient 2   ER/Outpatie	ent 3 DOA Other: 4 Nursing Ho	ome 5 Residence	6 ☐Other (Specify	)
	on of ding Phys n. After this funeral di		27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year)	of 28c. Injury at Work?	28d. Describe how in	jury occurred	
	isior ttendin death. ctor: Afr	atio	1 ☐Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No			
	ViS Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, Sta	and Number or Rural	Route Number,
	S affe of long of in the long of in	Seri	Dullding, etc. (Specify)		Ony or 10mm, On	110)	
	lospit hours unera	cai (	29a. Certifier (Check only (Ch	th occurred at the time, date and place,	and due to the cause	(s) and manner as sta	ated.
	Division of Vita within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	one) and manner stated.  29b. Signature and title of certifier	29c. License number		Date signed (Month, D	
	T wit	-		D 559 107			
	0		V-A M D		112	-01-200	5
	7		30. Name and address of person who completed cause of death (Item 23a) (Type				
	1			SAVINUE BALT	more.	M.D 212	213
		ate	31. Date filed (Month, Day, Year)  DEC 0 5 2005  32. Registrar's Signature	A			
	Regist	reir	DEC 0 5 2005	nach s			

		1 - For State Registrar	State of N	/larylar		rtmen <i>tificat</i>			Me		giene	UU;	)	39104
Physici /Medic		Decedent's Name (First, Middle, Last	Elizabe	eth V	eronica	Ros	tek		1	Date of De Month Novemb	Day		eer 05	3. Time of Death 12:50 PM
Examir		4a. Facility Name (If not institution, give	street and numbe	nr)		4b. City,	Town, or	Location of De			- T	County of		
		1711 Taylor Aven	ue			]	Parky	ville			,	Balt	imo	ore Co.
Funeral Director		5. Social Security Number 6. Social Security Number 1	9x 7. / □ M 2□xF	Age (In yrs. 79	last birthday) Yrs.	If Under Months		If Under 24 H Hours Mi	n.	Date of Bir (Month, Da Oct.	y, Year)		Cour	place (State or Foreign ntry) rland
Pu &		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty. Town or Lo	ation								04 1-14-01-11-1
sho	5			100.01	ty, rown or Lo	Jation							1	0d. Inside City Limits 1 ☐ Yes 2 🛣 No
the N	Director	Maryland Balti 10e. Street and Number	more			104 7:-	Cada	Pa	arkı	ille	10- 0''			
with			<b>***</b>			10f. Zip	Code	21234			-	zen of Wha		,
eath ne 23	era	1711 Taylor Ave	12. Was Deceder	nt Ever in U	IS 13 V	Vac Docor	dent of Hi	spanic Origin?	(Specifi	y Yes or No		ed St		
ife, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28e-f show other treumatic event, its Madral Examinations is notified at	by Funeral	1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces 1 Yes 2 G If Yes, Give Year or Dates	s? ≩No	11	Yes, spec	cify Cuba	Specify:	erto Ric	an, etc.)		Black, Specify:		
2 hou		15. Decedent's Ed	ucation		16a. Deced	ent's Usua	al Occupa	tion			16b. Ki	nd of Busir	ness/Inc	
21215-0036 od within 72 hours af gione. or then "natural; or it to Medical Exerci-	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  8 Years  (Give kind of work done during most of working life. DO NOT use retired)  Homemaker								Own H	Iome			
Hyg ent.	40	17. Father's Name (First, Middle, Last)						18. Mother's N	ame (F	irst, Middle	. Maiden			•
Maryland d 2 should be flie th and Mental Hy T Is marked oth treumatic event	To B	Joseph P. Kowal					l			Sczo				
Aary 2 sho 1 and 1 1s mu		19a. Informant's Name/Relationship (7		ugl te:	r) <sub>19b. Mailin</sub>	g Address	(Street a	nd Number or I	Rural R	oute Numb	er, City o	r Town, Sta	ate, Zip	Code)
ore, M s 1 and 2 of Health Hem 27 I		20a. Method of Disposition	Zeliski	20b. i	171 Place of Dispos	1 Tay	ylor	Ave. I	Park Date	ville				21234
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item; any njury or other once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		te	cemetery, crem	atory or o	ther place					20c. Location - City or Town, State		
IIIII		21. Signature of Funeral Service Licen		S	t. Star	Name an	d Addres	s of Facility						Maryland
Dep Pem Impo			<u> </u>		D <sub>1</sub>	uda-F 922 W	Ruck ise	Funeral Ave. D	Ho und	me of alk, 1	Dun Marv	dalk, land	In 21:	C. 222
Physician /Medical		shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
cate be executed physicien end the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	evic	RES			FATIL OBS-			Du	sfn3		SYGARS
the death certification of the death certification of the attending of the death of	Physiclan/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 3 No 9 □ Unknown	d. 23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	aldeath 3 ☐	Ectopic pr Other (sp					V4	23d. Date o Month		ry Day Year
wrequires that been signed by should be detail	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use  CRESION ACUAR ACUIDENT										contribute to the cause of death?		
r VI(al HECC ysiclan: The law re is certificete has be director, page 2 sho	Completed by								psy prior to completion of cause of death?					
VICAL P	Bec	25. Was case referred to medical examiner?						26. Place of De	eath (C		2 No			2X No
UNISION OF VITAL RECORDS, I or Attending Physician: The law requires I after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be.	ို	1   Yes 2 No  27. Manner of Death 1 Natural 5   Pending 2   Accident investigation	Hospital: 1 Inpa 28a. Date of In (Month, C		ER/Outpatient 28b. Time of Injury		8c. Injury Work	at Nursing		5 Resid			Specify	)
DIVISION O  To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Location							n (Street and Number or Rural Route Number, Town, State)				
Hospital     124 hours a     Funerel I	edical (	29a. Certifier 1 Sertifying Physics (Check only one) 2 Medical Exam	ysician: To the bes uner. On the basis and manner	or examina	owledge, death	occurred estigation,	at the time , in my op	e, date and place nion, death occ	ce, and curred a	due to the	cause(s) date and	and manne place, and	er as st	ated. the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	a signed (A	fonth, l	Day, Year)
		1 Dandlege	njom				D 3	6974			11	128	109	5
H		30. Name and address of person who of DAVIO O NYMNJ	om Mio.	107	24 LITTE		でよけ	NT PARK	WAY	e, Col				
Sta Registr		31. Date filed (Month, Day, Year) DEC 0 5 2005	32. Regis	strar's Signa	ature					-T		10		, ,

		ľ	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H			giene 005	39105			
			1. Decedent's Name (First, Middle, Last)		2. Date of Dea	ath Day Year	3. Time of Death						
	Physici /Medic		Ellen Emma Reiner					Novembe	er 29,2005	3:45 p <sup>M</sup>			
j	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or		ath	4c. County of Dea	ath			
			The Johns Hopkins	<u> </u>		Balti			N/A				
	Funeral Director		5. Social Security Number 213-20-8477 6. Sex	7. Age	(In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hi Hours Mi		v. Year)	rthplace (State or Foreign ountry)			
	DC &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits			
	sho	5			•					1 Yes 2 No			
	he M	ect	Maryland Carroll  10e. Street and Number	-	Westmi	10f. Zip Code			10 - 0'' 1''	^			
	with a or	늅	2110 Walsh Drive			2115	7		10g. Citizen of What C				
	ns 23	era	2110 Walsh Drive 21157 United State  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Black, White Black, White										
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "nature!, or items 23s or 28s-f show other treumsatic event, the Madical Examins must be notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 PDivorced	Armed Forces?  1 Yes 2 X N If Yes, Give Year or Dates:	10		Specify:	erto Rican, etc.)	Specific				
Ö	2 ho	Completed	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occupa	tion		16b. Kind of Business				
215	P. "n	ple	(Specify only highest grade		+) (Give	kind of work done d DO NOT use retired)	uring most of w	vorking					
21	filed with Hygiene. ther the	ő	Elementary/Secondary (0-12)	2 Years	Sec	retary			U.S. Gover	nment			
bu	al Hy al Hy I oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle,	Maiden Sumame)				
<u> a</u>	should band Ments marked umatice	2	Frederick W. Rein	er			Emma E	. Bailone	2				
an	12 should be filed v n and Mental Hygie 7 is marked other ireumatic event, in		19a. Informant's Name/Relationship (Type						r, City or Town, State,				
	Health Tem 27 other tre		Mildred Reiner -	Sister	160	2 Holly T	ree Roa	ıd Balti	imore, MD 2	21220			
ore	of He		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Dispo cemetery, crer	sition (Name of natory or other place		Date	20c. Location - City o	r Town, State			
Ĕ	Pages ment of l ant: If its ury or o		4 ☐ Donation 5 ☐ Other (Specify)			e Cemeter	y   12/	02/2005	Baltimore,	, MD			
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Selvice License	⇔Charles	F. Miner 22 Le	. Name and Address		5305 nc. Balti	Harford Ro imore MD 21	ad 214			
			23a. Part1. Enter the disease, or complice shock, or heart failure. Lisy only on	cations that caused						Approximate Interval Between			
	Pnysician	0 1	Immediate Cause (Final disease or condition Sepsis										
1	/Medical		resulting in death)	Due to (or as a	a consequence of):	_	-			Zacys			
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					3			
	cuted nd ransi	Examiner	that initiated events C										
0	e exe	Ä	resulting in death) Last	Due to (or as a	a consequence of):								
8760,	cate be executed physicien end the burial-transit	dical	C a										
9	ng ph as tl	Med	IF FEMALE:										
Вох	eath certific ettending p I for use as I	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth		Ectopic pregnancy			23d. Date of de				
	e dea	SIC	1 ☐ Yes 2 ☐ No	4☐Pregnant at i 9☐ Unknown	time of death 5	Other (specify)			Month	Day Year			
P.0	et the de d by the e etached	Phy	9 Unknown										
of Vital Records,	The law requires thet the death certificate be executed tie hes been signed by the ettending physicien end tage 2 should be detached for use as the burial-transit	þ	Part II. Other significant conditions con Stroke	tributing to death bu	it not resulting in the u	nderlying cause give	n in Part I.		bacco use contribute t es 2 □ No 3 □ P	robably 4 dunknown			
ပ္သ	aw requ s been 2 shoul	olet	Urmary tract	infection	\				24a. Was an 24b. Were autopsy findings av				
æ	The lav	Completed	Gastrointest	. 1 .	1			autop: perfor	med? prior to death? 2 → No 1 → Yes	completion of cause of			
tal		0	25. Was case referred to medical	nal Diec	9		26. Place of D	eath (Check only or		2 5 5 140			
>	Physician: r this certific ral director,	To B	examiner?	ospital: 1 Inpatier	nt 2 ER/Outpatien	t 3 DOA Othe	-		ence 6 Other (Spe	ecify)			
			27. Manner of Death	28a. Date of Injury (Month, Day	y 28b. Time of Injury	28c. Injury Work			ow injury occurred				
Ö	ttendin death. ctor: Afi y the fur	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(, 22)	,,		es 2 □ No						
Division	or Attendenter death offector: In by the	1	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Inju	ry - At home, farm, str	eet, factory, office		28f. Location (S City or Tow	itreet and Number or R	lural Route Number,			
Ö	s efter al Director	Certification;		guilding, old	. (Opcony)			Sily di 1011	ri, Stato)				
29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s									ause(s) and manner a date and place, and du	s stated. e to the cause(s)			
	To the Ho within 24 I To the Fu completel	29b. Signature and title of certifier 29c. License number 29d. Date signed								th, Day, Year)			
			Mitian.	MD.					December	01,2005			
1.	V		30. Name and address of person who co		eath (Item 23a) (Type,	Print)				)			
1	U		Wendy Ziai 600		e Street.		e MC	2128"	7				
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 5 2005	32. Registra	r's Signature	des.							

	4		For State Registrar	State of Maryland / Department of Health and Maryland / Certificate of Death	Mental Hygiene 005 39106
0	Physicia		1. Decedent's Name (First, Middle, Last,	SmiTH	2. Date of Death Month Day Year  Nevember 30 2005  M
	/Medic Examin		4a. Fecility Name (If not institution, give	street and number)  4b. City, Town, or Location of Death	4c. County of Death
				** T. Age (In vrs. last birthday) If Under 1 Year   If Under 24 Hrs.	
	Funeral Director		5. Social Security Number 6. Security Number 10. Security Number 1	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day Year) 9. Birthplace (State or Foreign Country)  NOV 1949 MARYLAND
	yland		10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	ith the Marylar or 28e-f show	ctor	MARYLAND N	IA BALTIMORE	C(T) 1A Yes 2 □ No
	vith th	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	ns 234	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	Decify Yes or No- 14. Race - American Indian,
936	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. If the ath art is marked other than "neturel", or items 23e or 28e-f show other treumatic event, the Madical Examinet must be notified at	by	1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Black, White, etc.  Specify: Black White, etc.
215-0036	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation 16a. Decedent's Usual Occupation e completed) (Give kind of work done during most of work	16b. Kind of Business/Industry
121	vithin ne. hen e	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	RV A-04 ST- TST- OFF
N	filed v Hygie other i		17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Maiden Sumame)
an	ould be filed with Mental Hygiene arked other thai atic event, Ire	To Be	CHARLES	WILSON REG	INA SMITH
Maryland	2 should be filed within and Mental Hygiene is marked other than sumatic event, It e M		19a. Informant's Name/Relationship (Ty		ral Route Number, City or Town, State, Zip Code)
_	1 and Health em 27	1 3		STEP-DAUGHTER 310 DRYON / 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
Jore	Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □ F	cemetery crematory or other place)	
		1	' 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fineral Service Licens	ee 22 Name and Address of Facility	-2005 BALTIMORE, MARYLAND
Ba	permit. Departr Importe any inji			JOSEPH H. BA	ROWN JR, FUNERAL HOME ON AVE, BALTO, MP 21217
	Medical Examiner	ner	shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Classes of Injuly)	Due to (or as a consequence of):  Due to (or as a consequence of):	Interval Between Onset and Death
	and and I-trans	Examiner	that initiated events resulting in death) Last	Due to (or se a consequence of):	
8760,	icate be executed physician and s the burial-transit			Due to (or as a consequence of):	
687	ificate g phys as the	edicai			
О. Вох	The law requires that the death certificate be executed its has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	33. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown	23d. Date of delivery  Month Day Year
rds, P	quires that n signed E uld be deta	by	Part II. Other significant conditions con	SAUCELOESES TESPINATing	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Records,	The law requir te has been si age 2 should l	Completed		STAGE RENAL DISEASE.	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
		BeC	25. Was case referred to medical	26. Place of Deat	th (Check only one)
of V	Physicien: this certifici ral director,	2	1 □ Yes 2 □ No	Associated: 1 Department 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6 Other (Specify)
		tlon:	27. Manner of Death  1 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred
Division	I or Attendate after death Director:	Certification:	2 Accident 3 Suicide 4 Homicide	28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one)	sician: To the best of my knowledge, death occurred at the time, date and place, ner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
	To the To the comp	ŭ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
•	a			May 1 mg D 1950 y	Newtones 30, 2005
1	( '			omptoted cause of death (Item 23a) (Type, Print)  AGA  AMA  AMA  AMA  AMA  AMA  AMA  AM	NEUTONISTON 30, 2005- THINETT HESPITAL CONTING TONN, MANYLAND 21133
	Sta Registr	-(-1	31. Date filed (Month, Day, Year) DEC 0 5 206	32. #egistrar's Signature	orio, v-cinquian oriis

			For State Registrar	State of M		epartment Certificate			d Mental Hy	giene	11117	391	08	
			1. Decedent's Name (First, Middle, Las	st)					2. Date of De Month	eath Day	/ Ye	3. Time o	of Death	
	Physici /Medic		Lucille B. S	averino					Decemb	er I	, 200	5 8:47	A M	
	Examin	100	4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or	Location of D	eath	4c.	County of D	eath		
			Montgomery Gener				ney				ntgom			
65	Funeral	3.5.5	5. Social Security Number 6. S	ex 7. Ag □M 2X1F	e (In yrs. last birtho	Months		If Under 24 Hours M	lin. (Month. Da	av. Year)		Birthplace (State Country)		
	Director		160-20-8058 Usual Residence of Decedent		78 Yr	5.			Jan. 9	, 19	27 P	ennsylva	nia	
	and wo		10a. State 10b. County		10c. City, Town o	r Location						10d. Inside C	City Limits	
	Mary	jo	Maryland Montgom	erv	Silver	Spring						1 🗀 Yes	s 2 XNo	
	the 28s	Director	10e. Street and Number	Cly	BIIVEI	10f. Zip				10g. Citi	zen of What	Country?		
	3a or		12518 Bushey Driv	P		20	906			II	S.A.			
	ma 2	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.			ispanic Origin?	(Specify Yes or No Jerto Rican, etc.)		14. Race - A	merican Indian,		
9	or ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 📉	No	1 Yes, spec			Jerto Hican, etc.)			/hite, etc.		
Ö	72 hours after death with the Maryland naturel; or Itema 23a or 28a-f ehow Iteal Examiner must be notified at	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Li Yes 2	240J NO	Specify:			Specify:	White		
21215-0036	be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "naturel", or Hema 23a or 28a-1 show of other then "naturel", or Hema 23a or 28a-1 show event, the Madical Extending mast be notified at	Completed	15. Decedent's Ed (Specify only highest gra		(0	ecedent's Usua Give kind of wor	rk done i	during most of	working	16b. Ki	nd of Busine	ss/Industry		
21	within then "	npfu	Elementary/Secondary (0-12)	College (1-4or	5+)	fe. DO NOT us		,						
21	filed withi Hygiene. other then		12		Ex	ecutive	Sec					ernment	-	
Pu	be fill	Be	17. Father's Name (First, Middle, Last)						Name (First, Middle	, Maiden	Sumame)			
Σ	should be ind Mental marked o	ျှ	Mike Formica				10:	Rose						
Maryland	01 (0 44 (5)	l I	19a. Informant's Name/Relationship (						Rural Route Numb		,			
	1 and 2 Health tem 27 othar tr		Roosevelt Saveri	no (Husbai	1d) 125 20b. Place of D			or., Si	lver Spri			or Town, Slate		
Baltimore,	it of h		1 Burial 2 Cremation 3 C	Removal from State	cemetery,	crematory or of	ther plac				•			
tim	permit. Pages Department of H Important: If Ite any injury or of once.		4 □ Donation 5 🖸 Other (Specif		it St. Ani			-		Wind	dber,	PA		
3al	Deparenti Deparenti Importanti any ir		21. Signative of Funeral Service Licer	1/2//		Meek Meek	Fune	ss of Facility eral Ho	me					
	TOPEGG		Lunia	Min	un				., Windbe		A 1596	_		
§ .			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each l	ne.	enter the mode	e or ayın	ig, such as can	diac or respiratory a	irrest,		Approxima Interval Be Onset and	etween	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Pancre	atic Canc	er								
100	/Medical Examiner		resulting in death)		a consequence of)									
		_	Sequentially list conditions,	D	Metastasi a consecuance of									
	led sit	ulu	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury											
	and al-trar	хаг	that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	:						-		
8760,	death certificate be executed e attending physician and of for use as the burial-transit	Physician/Medical Examiner												
687	phys phys s the	olb(		_ d.										
	leath certifica attending ph I for use as th	/We	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of	delivery		
Вох	atter   for L	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)							Month	,		
0	at the de by the a	ysi	1 ☐ Yes 2 🗖 No 9 ☐ Unknown	9□ Unknown			,,							
Д.	res that igned b		Part II. Other significant conditions of	ontributing to death t	out not resulting in the	ne underlying ca	ause giv	en in Part I.	23e. Did	tobacco u	ise contribut	e to the cause of	death?	
ds.	uires Id be	d by							1 🗆	Yes 2	X No 3□	Probably 4	]Unknown	
Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed							24a. Was	an	24b. Were	autopsy findings	s available	
Re	The lav	mc						-		ormed?	death		cause of	
Vital	ician: Th certificate rector, pag	CO	25. Was case referred to medical					36 Place of	1 ☐ Yes Death <i>Check only</i>	2. No	1 🗆 '	res 2□ No		
S		00	examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 📉 Inpati	ent 2 ER/Outp	atient 3⊡ DO	Oth	or	g Home 5 ☐ Res		6 COther (9	Spacety)		
o		7: To	27. Manner of Death	28a. Date of Inju	ıry 28b. Tin		8c. Injun Wor		28d. Describe			pocny)		
ion	Attending Professional Attention of the funeral by the funeral attentions.	io Io	1 ANatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ı <i>y Year)</i> İnji	M M		k? Yes 2 □No						
Division	r Attendi er death. rector: A by the fu	Certification:	3 Suicide 6 Could not b	28e. Place of in	jury - At home, farm	street, factory	, office					Rural Route Nur	mber,	
Ö	al or afte Dire	ert	4   Homicide	building, e	tc. (Specify)				City or To	wri, State	)			
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		29a. Certifier 1X Certifying Ph	ysician: To the best	of my knowledge,	death occurred	at the tin	ne, date and pl	ace, and due to the	cause(s)	and manne	as stated.		
	24 Ho	Medical	(Check only 2   Medical Examone)	niner: On the basis of and manner si	or examination and/ ated.	or investigation,	in my o	pinion, death o	ccurred at the time,	date and	place, and	due to the cause(	s)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ž	29b. Signature and title of certifier	$\bigcap_{\alpha}$		\ \		e number			-	onth, Day, Year)		
			) intell	RIVI	~	1	4	5014		Deco	MRIN	1/2	005	
,	1		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	pe, Print)					1	1		
4			ISASSUM M	RTIRE	no 1811	1 PRIN	R	PIHLLI	· Re c	LNI	57 17	20432	_	
1	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	rar's Signature	1-0					-	- d -		
	Regist	rar	DEC 0.5%	005	se B.	Coale	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen 05 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 30 aos Physician Santos 11:47 AM Kaymond November /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Medical If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 8. Date of Birth (Month, Day, Year) 1**∑**M 2□F Months Days Hours Min. 87 Yrs 580-56-1948 10, 1918 New York Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 1 ☐ Yes 2 📉 No Directo Odenton Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21113 United States 530 Realm Court East Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Puerto Rican white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Business 5+ Civil Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Antonio Santos Helen Garsik 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 530 Realm Court East, Odenton, MD 21113 Milagros Santos/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State West Arundel Crematory Dec. 3, 2005 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Rd. Odenton, MD 21113 21. Signature of Funeral Service Licenses somenico amodeo Approximate Interval Between Onse and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final shock disease or condition resulting in death) dou Due to (or as a consequence of): and gram regative bacteremia positive dau Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? abelic acidosis, aute renal 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 1 🗔 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. Inpatient 2 ER/Outpatient ဥ 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending M 1 ☐ Yes 2 ☐ No investigation 2 Accident

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for nease the burnet trans. P.O. Box 68760 Division of Vital Records,

**Funeral** 

Director

or 28a-f ehow

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the Madical Exertines must be notified at

other traumatic event,

5 permit. Page Department of Important: If any injury or once.

**Physician** 

/Medical

ages 1 and 2 should be fill out of Health and Mental Hittin 27 Is marked other

Registrar

Mon

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

00022483

November 30, 2005

STUDET JACOBS MD 305 Nospital Dr. Glen Burnie, MD

31. Date filed (Month, Day, Year) DEC 0 5 2005

3 ☐ Suicide

29a. Certifier

Medical

4 | Homicide

(Check only one)

29b. Signature and title of certifier

32. Registrar Signatura

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Amend item#8, perFH, C850, 12/6/05 TT State of Maryland 7 Department of Health and Mental Hygiene 15 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Dennis Rae Sayers 2, 2005 December 1:10 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death Examiner 1819 Blue Jay Court Severn Arunde1 Anne If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 5, 194 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. 1941 Director 372-42-8341 64 Michigan Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ir than "naturai", or items 23e or 28e-f show The Medical Examiner must be notified at 1 ☐ Yes 2 🛱 No Director Maryland Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Completed by Funeral 1819 Blue Jay Court 21144 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1∑(Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify 3X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mentat Hygien Important: If itam 27 is marked other It any injury or other traumatic event, ILs oncs. 5+ Civil Service Linguist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Rae W. Sayers Barbara Η. 0akes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bridget E. Hilder/daughter 702 Birch Ave. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c, Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) West Arundel Crematory 12/3/2005 Odenton, MD 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P. 1411 Annapolis Road, Odenton, MD 21113 21. Signature of Funeral Service Licensee Domenico amodeo 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Arrhythmia /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease, Hypertension & Hyperlipidemia 14 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit The law requires that the death certificate be executed Type 2 Diabetes Mellitus 14 years that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physician/Medical Obesity the as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☐ No Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Depression been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2X No certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attanding Physician: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:  $_{4\,\square\,\text{Nursing Home}}$  5  $\square$  Residence 6 XOther (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No 2 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 34149 2005 gwadel X 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Zavadil, ΙΙΊ, MD 10810 Hickory Ridge Rd. Columbia, MD Anthony P. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 5 2005 Registrar

			For State Registrar	State of Ma	aryland /		artment o <i>tificate d</i>				iene) () ;	5 3	39111
	Physicia	an	1. Decedent's Name (First, Middle, Last,						2	2. Date of Deat Month Iovembe:	h Day	Year	3. Time of Death
	/Medic			SNYDER						lovembe:		005	2:35 p M
	Examin	er	4a. Facility Name (If not institution, give Prince George's H	ospital C			Cheve	<i>-</i>			4c. County Princ		orge's
	Funeral Director			7. Ag	e (In yrs. last b 76	Yrs.	If Under 1 Ye Months Da			B. Date of Birth (Month, Day, IOV • 27	Year) 1929	9. Birthp Cour Ind:	lace (State or Foreign try) Lana
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Lo	cation					1	0d. Inside City Limits
	f sho	ō	MD Montgom	erv	Silve	er Sr	oring						1 ☐ Yes 2 ☐ No
	28e-	rec	10e. Street and Number				10f. Zip Cod	de		1	0g. Citizen of V	Vhat Cour	
	h with	Funeral Director	3152 Gracefield R	oad #319			2090	4-0800			U.S.A.		
	deat	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Was Decedent f Yes, specify (	of Hispanic Or	igin? (Speci	fy Yes or No-		e - Americ k, White,	an Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural; or items 23a or 28e-f show other traumatic event, the Madical Exeminar must be notified at	y Fu	1 Never Married 2 🗓 Xuarried	1 ☐ Yes 2 🛣 If Yes, Give	<b>%</b>	1	I□Yes XXX			-L., -10.,	Specify		
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15	in 72 "naf	olete	15. Decedent's Edu (Specify only highest grad	e completed)		(Give	kind of work do DO NOT use re	one durina mos	st of working		16b. Kind of Bu	sinessin	oustry
212	jene.	Completed	Elementary/Secondary (0-12)	College (1-4or 5 5 +	5+)	Nucl	Lear Ph	ysicist	:		U.S. G	overr	nment
힏	e files al Hyg I othe vant,	Be C	17. Father's Name (First, Middle, Last)								Aaiden Surnam	Θ)	_
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<u>Jar</u>	2 sh and is m raum		19a. Informant's Name/Relationship (T)								City or Town,		
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nor	ages int of t: If It y or o	3	1 ☐ Burial 2 🖾 Øremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)		cemet	ery, cren	natory`or other idel Cr	place)	7 12/	1/2005		•	Maryland
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k	Pnysician	0.1	Immediate Cause (Final disease or condition	Muli	tions	la	mD.	gas	n Fa	elle	re		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or 16	a cor suence	e of):		0					
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Вох	death certifii e attending p id for use as	lan	in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al	2 Fetal deat		Ectopic pregna Other (specify				23d. Date Mor	e of delive oth	ry Day Year
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Ω.	s that the ned by th e detache	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting	in the ur	nderlying cause	given in Part		23e. Did tob	acco use contr	ibute to th	e cause of death?
rds	w requires been sign should be									1 □ Ye	s 2 No	3 ☐ Prob	ably 4 □Unknown
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H	The ate h page	Com								perform	18g4? C	eath?	
Vital	clan: T ertificate ector, pa	Be (	25. Was case referred to medical examiner?	2/					of Death (	Check only on	э)		
of	Physician: this certific ral director,	To	1 ☐ Yes 2 No  27. Many fer of Death	dospital: 1 Inpatie		outpatien. Time of	1 3 DOX	Other: 4 No			nce 6 Othe		)
	ding h. h. After funer	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury		Work? 1 ☐ Yes 2 ☐		d. Describe no	w injury occurs	50	
Division	al or Attending P s after death. Il Diractor: After t id in by the funera	ifica	3 Suicide 6 Could not be	28e. Place of Inj	ury - At home,	farm, stre						er or Rura	I Route Number,
ā	s afte	Certification:	4  Homicide	building, et	с. (Зреспу)					City or Town	, 3(2(0)		
	To the Hospital or At within 24 hours after d To the Funarel Diract completely filled in by	edical	29a. Certifier (Check only one) Certifying Phy	sicien: To the best ner: On the basis o and manner st	f examination a	ge, death ind/or inv	n occurred at the restigation, in n	e time, date ar ny opinion, dea	nd place, and th occurred	d due to the ca at the time, da	use(s) and ma ite and place, a	nner as st ind due to	ated. the cause(s)
	To the within 2 To the complet	Ň	29b. Signature and title of certifier	1	70.0am		29c. Lic	ense number		25	d. Date signer	(Month,	Day, Year)
•	4		1/ /well	ne		,		30	3/8	2	11/2	9/	05
7	0		30. Name and address of person who co James Catevenis,		leath (Item 23a ince Ge			pital (	Center	Cheve	erly, M	D	
	- 01	to.	James/Catevenis, 31. Date filed (Month, Day, Year)	A	1. 0:			prour (					
	Sta Registi		DEC 0 5 2005	filelus-	ar's Signature	AS CO.							

State of Maryland / Department of Health and Mental Hygiene 🛭 🕦 5 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year December 1, 2005 Physician 10:00 PM Sala, Jr. Vincent /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Manor Care Rossville Baltimore Co. Rossville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 → M 2 □ F Yrs Director 212-28-7478 July 22,1932 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Maryland Baltimore Essex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 7 Fore Court 21221 United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1♥ Yes 2 No If Yes, Give Year or Dates: Korean 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2√☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than. Elementary/Secondary (0-12) College (1-4or 5+) Painter Painting 6 Years and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lena Picker Vincent Sala, Sr. ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau 2901 Dunmore Road Dundalk, Maryland Mr. Vincent Sala, III (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1.⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/6/2005 Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Fart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Probable **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Status part Larryn fecto orryngeal Comely Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Hypercaleann that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Deelme 1 Yes 2 No 3 Probably 4 Minknown peen 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 1 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case reterred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After the funeral of 2Ba. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 BNatural 5 Pending To the musping within 24 hours after death.

To the Funerel Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mo MD D 31464 12/2/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 821 N. ENTAN ST fute 308, MITIMORE MI) 20201 HASHMI MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

DEC 0 5 2005

		1	For State Ragistrar	State of M	aryland	-	artment tificate			nd M		giene Rag. No.	05	39113
			1. Decedent's Name (First, Middle, Last)								2. Date of Dea Month		Year	3. Time of Death
Phys /Me	dica		Al Stephen Sanfo	rd							Nov 28,	7		1825 M
Exar			la. Facifity Name (If not institution, give s		r)				Location of	f Death			nty of Death	
			2605 Southern Ave,				Temp.		Hills If Under 2	DA Hre	2 D (Dist		ce Ge	
Funer Direct			5. Social Security Number 6. Sex 183–44–5152  Usual Residence of Decedent	M 2□F	49	ast birthday) Yrs.		Days	Hours	Min	8. Date of Birtl (Month, Day Aug 5,	1956	9. Birth Cou	place (State or Foreign intry) PA
and		1	10a. State 10b. County		10c. City	, Town or Lo	cation				•			10d. Inside City Limits
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after at a	į	2	1 Never Married 2 Married	1 Yes 2	<b>X</b> No		1 🗆 Yes 2		Specify:	,		Spec	- 14 .	
Jours Nours	1	a b	3 Widowed 4 Divorced	Year or Dates	:								Бта	
If a reference after death with the Maryland Hygiene. Hygiene. Hybrithen "naturel", or Iteme 23a or 28e-f ehow mit, the Maryland Examination manke notified at mit, the Macileal Examination or the model.		Сотріете	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	ient's Usuaf kind of work DO NOT use	Occupa done d	tion <i>uring most</i>	of worki	ng	16b. Kind of	Business/lr	ndustry
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lid be lental ked c	9	0	Charles Sanford						Rub	y Wi	lson			
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants: if Item 27 is marked other than "naturely, or Items 23a or 28e-f show enty injury or other thaumatic event, the Machina Laurely, and Items 23a or 28e-f show enty injury or other traumatic event, the Machina Examination and any injury or other traumatic event, the Machina Examination and any other traumatic event, the Machina Examination and any other traumatic event, the Machina Examination and any other traumatic event, the Machina Examination and any other traumatic event, the Machina Examination and any other traumatic events.			20a. Method of Disposition 1 ☐ Burial 2 【文Cremation 3 ☐ R	emovaf from Stat	e C6	lace of Dispo emetery, crer	natory or oth	er place	- 1		ate	20c. Location		
t. Pa rtmen rtent:		-	4 Donation 5 Other (Specify)  21. Signature of Juneral Service License	1	Bayv	riew Cı				1-30		altimo	re, M	ע
Department of the control of the con	500		Gregory Find		01148		Name and Fink F							1061
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Physicia /Medic			disease or condition resulting in death)	Due to (or a	as a consequ	lence of).	2 ITY	P	e15	タノン	e Hea	n s	is eas	2
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certif ding		VMe	IF FEMALE: 23b. Was decedent pregnant	3c. ff yes, outcom	ne of pregna	ncy						23d. [	Date of defiv	rerv
death a atter		Clar	in the past 12 months?	1□Live birth 4□Pregnant	at time of de		Ectopic pred Other (spec						Month	Day Year
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To the Hospital or Attending Physician: The implies 4 hours after death. To the Funeral Director: Atter this certificate his completely filled in by the funeral director, page		Medical	29a. Certifier (Check only one)  1 Certifying Physical Call Examination		of examinat									
To the To the		ž	29b. Signature and title of certifier	11	0		29c.	License	number			29d. Date sign	ned (Month,	Day, Year)
6			falada,	The	00 6	20		H	0054	34	2/ 1	Novem	lear	30, 2005
2			30. Name and address of person who co	mpleted cause of	death (Item	23a) (Type,	Print)	I	n've	9	Chever	4 1	war.	lom a
	Stat istra	_	31. Date filed (Month, Day, Year)	Mr.	strar's Signa	ture	call B		-			01		<del></del>
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			For State	State of Maryland		rtment of Health ar	nd Mental I	1	UU5	39114
			Registrar  1. Decedent's Name (First, Middle, Last)		0011	meate of Death	2. Date of	Reg. No	o.	3. Time of Death
	Physici	an	EMAN CONTRACTOR		5	000	Month	, Da		r ====================================
	/Medic		-/IMNUEL	tmat and number)		4b. City. Town, or Location of	i i	125	/2004 c. County of De	
	Examin	er	4a. Facility Name (If not institution, give s	La correl		46. City, Town, or Location or	Death	40	. County of De	
			5. Social Security Number 6. Sex	7. Age (In yrs. last	highday	If Under 1 Year   If Under 24	Hrs. 8. Date of	Dieth	NI	listratora (State or Familia
	Funeral			M 2□ F 7. Age (117 yrs. 1851	Yrs.		Min. (Month,	Day, Year		firthplace (State or Foreign Country)
н	Director		Usual Residence of Decedent	70			10-	29-	33	J.C.
	land		10a. State 10b. County	10c. City, T	own or Loc	ation				10d. Inside City Limits
	Marylan fehow ied at	ō	Md. BALTEI	4006 /3	PIT	emore				1 ☐ Yes 2 No
	28e-	ect	10e. Street and Number	TURC TO	10/1	10f. Zip Code		10g. C	itizen of What	Country?
	hours after death with the Maryland turel', or Items 23a or 28e-f ehow al Examiner must be natified at	Funeral Director	1001 BOX	11. 100 Ola	H ,	2/2	72		4.5	•
	ns 23	era	11. Marital Status	2. Was Decedent Ever in U.S.	13 W			No-		nerican Indian,
	iten iner	Į.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 MYes 2 □ No	lf.	as Decedent of Hispanic Origin Yes, specify Cuban, Mexican, I	Puerto Rican, etc.)		Black, Wi	
36	Irs af	by	3 ☐ Widowed 4 ★ Divorced	If Yes, Give Year or Dates: / 964 - 3	ا رم	☐ Yes 2 No Specify:			Specify:	Start
5-0036	72 hours neturel',	eq	15. Decedent's Educ		6a. Decede	int's Usual Occupation		16b. h	Kind of Busines	s/Industry
215	in 72 n "net	Completed	(Specify only highest grade		(Give k.	ind of work done during most o O NOT use retired)	f working		_	,
212	within iene. then "	uo ou	Elementary/Secondary (0-12)	College (1-4or 5+)	Gard.	SERVICE 1	novasc.	0 5	UPERN	eneke T
T	filed Hygi other ent,		17. Father's Name (First, Middle, Last)	0.77.0	-		s Name (First, Mid	ldle, Maidei	n Sumame)	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
an	ould be Mental arkad c atic eve	To Be	GENDES	SPAR		Pro	e, /.	300.	160	
Marylan	2 should be filed and Mental Hygi is markad other aumatic event,	F	19a, Informant's Name/Relationship (Type	ne. Print)	19b. Mailing	Address (Street and Number	or Rural Route Nu	mber. City	or Town, State	Zin Code)
Ma	01 00 00 00	,		ETTE SABA	201	Sand Sural	7	200	211 /	7035
e)	1 and 2 Health em 27	-	20a. Method of Disposition	20b. Place	e of Disposi	tion (Name of	Date	20c. L	ocation - City	or Town, State
ŏ	o = 5		Burial 2 Cremation 3 Re	0.000	etery, crema	atory or other place)	2/1/			
altimore,		1			12501	V HOREST			INAS	
Bal	permit. Departm Importe eny inju		21. Signature of Funeral Service License		22.	Name and Address of Facility	BEVERY	IP.	Cron	ratie 7/5
_	4 D ≒ ⊕ Ø		man fel	romance	59	43 CHARLE	551-	300	To, M	W. 21207
П			23. Part. Enter the disease, or complic shock, or heart failure. List only on	cations that caused the death. [ e cause on each line.	Do not enter	the mode of dying, such as ca	rdiac or respirator	y arrest,		Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition	ENTERDOOCO	us	SEPTICEM	IA			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequen						
	Examiner		Sequentially list conditions							
		Je.	if any leading to immediate	Due to (or as a consequen	ice of):					
	cuted id ansi	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events							
ó	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	Due to (or as a consequen	ce of):					
8760	ate be hysicia the bu	dicai	d							
9	ificate g phys as the	edi	7-17-0							
Вох	death certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy				}	23d. Date of d	elivery
B	atte of for	cial	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death		ctopic pregnancy Other (specify)			Month	Day Year
P.O.	y the	ıysi	9 Unknown	9□ Unknown						
	es that the de igned by the a be detached t	P P	Part II. Other significant conditions con-	tributing to death but not resulting	ng in the und	lerlying cause given in Part I.	23e. D	id tobacco	use contribute	to the cause of death?
of Vital Records,	sign d be	Completed by	DIABETES				1	☐ Yes 2	<b>1</b> 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4 Unknown
o	w requir been si should	ete		1011					0.011	
še	has has ge 2 s	npi	HYPER TENS				24a. W	ras an utopsy erformed? "	prior to	autopsy findings available completion of cause of
Ä	sicien: The l certificate ha rector, page	Col	RECENT ST	ROKE			1 ☐ Ye			es 2 No
/ita	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				f Death (Check on			
) t	Physi this c	유	1 185 2 200		/Outpatient		ing Home 5□R			ecify)
	ng P	ino	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28 (Month, Day Year)	b. Time of Injury	28c. Injury at Work?	28d. Descri	be how inju	ry occurred	
Division	vttendin death. ctor: Aft y the fun	ati	2 Accident investigation			M 1 Yes 2 No	•			
<u>×</u>	or Attendater death	ţį.	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	at, factory, office	28f. Locatio City or	n (Street au Town, State	nd Number or I	Rural Route Number,
	tel or A s after al Direc ed in by	Certification:					<u> </u>			
	Hospi 24 hou Funer tely fill	Medicai	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowle er: On the basis of examination	dge, death of and/or inve	occurred at the time, date and stigation, in my opinion, death	place, and due to to occurred at the tin	he cause(s ne, date an	) and manner a d place, and di	as stated. ue to the cause(s)
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Med	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Da	ite signed (Moi	nth, Day, Year)
	- s - ō		Ac . c . 12 1	wasterva		D00633	7	1 -	2/2	105
, ,	1		7,70		) (T		~ (	1	- 1 -	100
n	1,2		30. Name and address of person who cor	·			21215			
			2434 W. Belved 31. Date filed (Month, Day, Year)				メノイン			
	Sta Registi		DEC 0 5 20	32. Registrar's Signature	K A	make)				

			1- State of Maryland / Department	artment of Health and M rtificate of Death		2005	39116
	Dhysiai	20	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Cassel H. Talbott		November	30, 2005	6:49 AM
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
ı			Laurel Regional Hospital	Laurel If Under 1 Year   If Under 24 Hrs.		Prince Ge	
П	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. The first of the	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cou	place (State or Foreign ntry)
			Usual Residence of Decedent		Oct 14,	1926   Vir	ginia
	yland		10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	a-fs	ctor	MD Prince George Beltsvill	е			1 X Yes 2 ☐ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g	. Citizen of What Cou	ntry?
	23a		5017 Quimby Avenue	20705	U	.S.A.	
	ar de:	Funerai	Armed Forces?	Was Decedent of Hispanic Origin? (Spe f Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
9	', or l	by F	1 ☐ Never Married 2 【X Married 1 【XYes 2 ☐ No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes 2 🕅 No Specify:		Specify: Whit	
3	hou	ed t		dent's Usual Occupation	16	b. Kind of Business/Ir	
<u>د ا</u>	n "ng	Completed	(Specify only highest grade completed) (Give	kind of work done during most of worki DO NOT use retired)	ng	5. Talk of Eddiness in	idustry
7	illad with Hygiene ther tha	E O		Driver	ı	ron Works	
פ	be tilad within 72 hours after death with the Maryland ital Hygiene dother than "natural", or Itams 23a or 28a-f show event. It e Modical Exerciting from the modifical event.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>a</u>		10	James Marcus Talbott	Lula Beal	ll Clifto	n	
Maryland 21215-0036	0 0 00 0		19a. Informant's Name/Relationship (Type, Print) 19b. Mailir	ng Address (Street and Number or Rura	l Route Number, C	ity or Town, State, Zij	Code)
	1 and 2 Health em 27 othar tr			Quimby Avenue, Bel		1	
0			1 M Burial 2 Uremation 3 Hemoval from State 1	natory`or other place)	ate 20	c. Location - City or To	own, State
<u> </u>	tent:	l a	`4 □ Donation 5 □ Other (Specify) IVY Hill			aurel, Mar	yland
Baltimore,	permit. Page Department of Importent: If eny injury or once.		21. Signature of Funeral Service Libensee	Name and Address of Facility Onaldson Funeral H	Home, P.A		707 4200
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent	13 Talbott Ave. La			Approximate
1			shock, or heart tallure. List only one cause on each line.				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)  a Arterio Sciencti Due to (or as a consequence of):	c Cardiovascular I	Disease		l year
	Examiner						
		ner	Sequentially list conditions, if any, leading to immediate causs. Enter or anying Cause (Disease or injury				
	ocutad nd Iransi	Examiner	that initiated events				
Ď	e execian a		resulting in death) Last Due to (or as a consequence of):				
8/6U	The law requires that the death certificate be executed te has been signed by the attending physician and age 2 should be detached for use as the burial-transit	dical	d				
o X O	leath certific attending p		IF FEMALE: 23c. If yes, outcome of pregnancy				
on	atten for u	Physician/Me	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
o	at the de by the a stached	ysic	1 Yes 2 No 9 Unknown	Other (specify)			
<u>,</u>	signad by		Part II. Other significant conditions contributing to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
ecords,	quires n sigr ald be	d by			1 ☐ Yes	2 ☐ No 3 ☐ Prot	pably 4 \textstyUnknown
000	sw requir s been si should	Completed			24a. Was an	24b. Were auto	psy findings available
r	sicien: The law certificate has l irector, page 2 s	om			autopsy performed 1 ☐ Yes 2 ₺	prior to co	mpletion of cause of
VII	(g C	a	25. Was case referred to medical	26. Place of Death		No 1 ☐ Yes	210 140
_	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 🛣 No Hospital: 1 ☐ Inpatient 2 🛣 ER/Outpatien	Othor		e 6 □Other (Specif	y)
n or	ding Phys h. Atter this funeral dir		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) Injury		8d. Describe how		
DIVISION	tendia death. tor: Al	catic	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Ë	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, strated building, etc. (Specify)	set, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura itate)	I Route Number,
_	urs al						
	To the Hospitel or Attending within 24 hours after death. To the Funarel Director: After completely tilled in by the funer	edical	29a. Certifier  (Check only one)  Check only one)  Check only one)  Check only 2 ☐ Medical Examiner: On the basis of examination and/or invane and manner stated.	i occurred at the time, date and place, a restigation, in my opinion, death occurre	ind due to the caus ed at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the within 3	Med	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month,	Day, Year)
	r s ⊢ ŏ		) the m	D24721		ovember 30	,
	1		30. Name and address of person who completed cause of death (Item 23a) (Type,		IN	PACTURET 20	, 2005
1	ŷ		Syed Sadiq, M.D. 14333 Laurel Bowie		Laurel,	MD 20708	
	Sta	te	31. Date filed (Month, Bay, Year) 32. Registrar's Signature	0			
	Registr	ar	man of many lateral and lateral				1

			1 - For State Registrar	State of I	Maryland /	Depa Cea	artment of He rtificate of D	ealth and leath		piepe 05	39117
	Physici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Deat	_	3. Time of Death
	/Medic		BERTIE			0			DEC	3 rd 200	
	Examin	er	4a. Fecility Name (If not institution,		er)		4b. City, Town, or L	ocation of Dea	th	4c. County of I	Death
			6336 Cedar Lane				Columbia			Howa	rd
	Funeral			5. Sex 7 1⊠M 2□F	Age (In yrs. last b			If Under 24 Hrs Hours Min			Birthplace (State or Foreign Country)
	Director		215-78-6907 Usual Residence of Decedent		89	Yrs.			June 25	5 1916	Georgia
	and T.M.		10a. State 10b. County		10c. City, To	wn or Lo	eation				10d. Inside City Limits
	Many f sh	ō	MD Howai	- 4	Col	umbi	2				1 □Yes 2 XNo
	the 28a	Director	10e. Street and Number	.u		unibi	10f. Zip Code		1	0g. Citizen of Wha	t Country?
	With Ba or		6336 Cedar Lane					044	,	-	-
	Jeath Tis 2:	era	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. \			Specify Yes or No-	USA 14 Bace - A	American Indian,
G	ifter after	Funerai	1 Never Married 2 Marrie			1	Was Decedent of Hisp f Yes, specify Cuban,	Mexican, Puèr	to Rican, etc.)		Vhite, etc.
ဇ္ဇ	ours a	by	3	If Yes, Give Year or Date:	•		1□Yes 2⊠ No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene.  9ne.  1 han "naturet", or items 23e or 28e-f show ha Medical Examiner must be notified at	Completed	15. Decedent's (Specify only highest	Education	16	a. Deced	dent's Usual Occupation	on	etria a	16b. Kind of Busine	ess/Industry
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. I	DO NOT use retired)	ing most or wo	rking		
ณ	filed w Hygier other the	Co	11th	Ø		Home	maker			Own Home	
פַ	ttal H d oth	Be	17. Father's Name (First, Middle, La	st)			18		me (First, Middle, M	,	
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. I firm 21 is marked other than "naturel", or items 23a or 28a-f show other traumatic event, the Medical Examinat must be notified at	2	John D. Prosser						Belle Sar		
<u>a</u>	h and		19a. Informant's Name/Relationship		F.		g Address (Street and				e, Zip Code)
ď	1 and Health em 27 ther tr		Andy J. Underwood  20a. Method of Disposition	od/Son			Gales Sti	reet, L			
و	Pages nent of I int: If its iry or o		1 Burial 2 ☐ Cremation 3		te cemet	ery, cren	natory`or other place)			20c. Location - City	
altimore,	it. Pi		' 4 □ Donation 5 □ Other (Spe 21. Signatur of Funeral Service Lice	denne p	Ariin		National			Arlingto	
Ва	permit. Pages Department of I Important: If its any injury or of once.		21. Signature of Funeral Service Like	1///	400777		. Name and Address				
			23a. Part1. Enter the disease, or co		M00773		13 Talbott				707
		7	shock, or weart failure. List or immediate Cause (Final	ly one cause on each	line.	TIOL BILL	ar the mode of dying, s	SUCH AS CARDIAG	or respiratory arre	981,	Approximate Interval Between Onset and Death
F	hysician /Medical		disease or condition resulting in death)	a	DENET	N71	Α				years
	Examiner			Due to (or	s a consequence	of):	7 - 7	Less.			he or time
		-	Sequentially list conditions, if any, leading to immediate	b. — Due to (or a	as a considuence	of):	tenno.				noults
	ned in sit	듵	Sequentially list conditions, if any, leading to immediate cause. Enter Under, ing Cause (Disease or injury		1.0						
,	exection and in all-tra	Examiner	that initiated events resulting in death) Last	c Due to (or a	is a consequence	of):					
8760	icate be executed physician and s the burial-transit			d.							
		ledicai							T. T. T.		
Вох	e attending pod for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. if yes, outcom	ne of pregnancy 2 Petal deatl	2 0	Establia esagge			23d. Date of	delivery
	0 0 0	sicle	in the past 12 months? 1 □ Yes 2.☑No	4☐Pregnant	at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
0.	by the	, by	9 Unknown	9□ Unknown							
s,	ine raw requires marine de te has been signed by the a page 2 should be detached to	by F	Part II. Other significant conditions	contributing to death	but not resulting	in the un	derlying cause given i	n Part I.	23e. Did toba	acco use contribute	to the cause of death?
ב י					-				1 ☐ Yes	s 2 □ No 3 □	Probably 4 Dunknown
Vital Records,	as be	Completed							24a. Was an	24b. Were	autopsy findings available
ř	rne rav cate has page 2 :	ĕ							autopsy perform 1 Yes 2	ed? death	
II I	ysteren: Tr is certificate director, pag	Be (	25. Was case referred to medical examiner?				26	3. Place of Dea	th (Check only one		30 32 10
o .	G ≅. 5	2	1 ☐ Yes 2 ☐ No	Hospital:	tient 2 ER/O	utpatient	3□ DOA Other:	4 Nursing H	ome 5 Resider	nce 6 Other (S	pecify)
	After th	ë.	27. Manner of Death 1 ☐ Matural 5 ☐ Pending	28a. Date of In (Month, D	jury 28b.	Time of Injury	28c. Injury at Work?		28d. Describe how		
ois i	er death. rector: After by the funer	cati	2 ☐ Accident investigat 3 ☐ Suicide 6 ☐ Could not	ho				2 □ No			
- :	after death. I Director: Af	Certification:	4 Homicide determine	d 286. Place of It	njury · At home, fa etc. <i>(Specify)</i>	arm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	S T D		29a. Certifier 1 Certifying								
			25a. Certifier Lacertifying i	mysician: To the bes	of examination ar	e, death nd/or inv	occurred at the time, estigation, in my opinio	date and place, on, death occui	, and due to the cau rred at the time, dat	use(s) and manner te and place, and d	as stated.
2	24 hour 24 hour 5 Funers stely fille	dica	one) 2 Medical Ex	aminer; On the basis							
	vithin 24 hour	Medicai	one) 2 Medical Ex	aminer; On the basis							
1	n 24 hou he Funer pletely fill	Medica	one) 2 Medical Ex	aminer; On the basis							
	within 24 hour To the Funers completely fills	Medica	one) 2 Medical Ex	aminer; On the basis		(Type f					
(c)	within 24 hour To the Funers Completely fills	Medica	one) 2 Medical Ex	aminer; On the basis		(Type, F					
(c)	within 24 hours within 24 hours of the Funers completely fills	V	one) 2 Medical Ex	aminer; On the basis		(Type, F					ue to the cause(s)  Inth. Day, Year)  ZOOS  IIO  WARRIA WOYS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Nina V. Walters November 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner Franklin Square timore HOSpita If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days 1 ☐ M 2 🔀 F Hours 212-02-7197 Director 40 Aug.6,1965 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 23a or 28a-f show the Madical Examiner must be notified at MD Baltimore Middle River 1 ☐ Yes 2 € No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 123 Mariners Point Drive 21220 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ō Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical marked other then Elementary/Secondary (0-12) College (1-4or 5+) Publisher Publication 12th 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Kenneth Minor Clara Chapman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton Walters Jr./husband 123 Mariners Roint Drive Balto.MD 21220 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State Baltimore MD HollyHillCemetery 12/3/05 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ConnellyFuneralHomeofEssex 21. Signature of Funeral Service Licensee 300 Mace Ave. Baltimore MD 21221 23a. art 1. Enter the disease, or co-n lications that caused the dishock, or heart failure. Lie of the one cause on each line. To not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** +AS+Atic /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗷 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? hes 2 1 No 1 Yes 2 No Division of Vital 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐/No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours after To the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 037612 Dec 1-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOODFranklin Square Orive Baltimore MO21251 A LA Brash Mo Hamad MD
31. Date liled (Month, Day, Year) 32. Registrar's Signature 1. 32. Registrar's Signature Registrar DEC 0 5 2005

Box 68760.

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Records.

			1 - For State Registrar	State of N	/laryland		artment tificate			and Mer		giene		39119	
147	Physici	an	1. Decedent's Name (First, Middle,	Last)						2.	Date of De Month	aath Day	Yea		
	/Medic	al	Margaret	-i- start and numba	-1		4h City T				ovemb	T .	, 2005		-
	Examin	er	4a. Facility Name (If not institution, s Southern Maryla				Clin		Location of	or Death			County of De		
*	- Funeral			. Sex 7. A	Age (In yrs. Ia	ast birthday)	If Under	1 Year	If Under	24 Hrs. 8.	Date of Bir (Month, Da		9. 8	George 's Birthplace (State or Foreig	 n
В	Director		493-36-4035	1□M 2ÅDF	81	Yrs.	Months	Days	Hours	Min.	t. 12	4, Year)		Couintry) Ouisiana	
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits	
	f eho	ō	MD Prince (	George's	1	Washi		1						1 Yes 2 No	
	r 28a-	Irect	10e. Street and Number				10f. Zip					10g. Citi	zen of What		-
	th with	by Funeral Director	6329 Stonewain	Court			207	44				USA			
	r dea	ner	11. Marital Status	12. Was Deceder Armed Forces			Was Decede	ent of His	spanic Ori	gin? (Specify	Yes or No	0-	14. Race - Ar Black, W	merican Indian, hite, etc.	
36	rs afte	y F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	_		1 ☐ Yes 2	₩ No	Specify:				Specify:	Black	
8	2 hou	ted	15. Decedent's	Education		16a. Deced						16b. Ki	nd of Busine:		
215	thin 7: en "n Madi	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4o	r 5+)	(Give life. L	kind of worl DO NOT use	k done d e retired)	uring mosi	t of working					
2	ygien ygien her th		12			Но	memak					1	Home		
and	ntal H	Be	17. Father's Name (First, Middle, La	(St)						r's Name <i>(Fi</i> t <b>tie</b> B		, Maiden	Sumame)		
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland Ind Mental Hyglene s marked other than "natural", or Itams 23a or 28a-f show umatic event, the Mudical Examinar must be notified at	ပ္	Albert Smith  19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	na Address	(Street a				er. City o	r Town, State	a. Zip Code)	
Σ S	alth ar 27 ls r trau		Thomas Winston	, , , ,			_						n, MD		
ore,	ss 1 a of Hea Item		20a. Method of Disposition			ace of Dispo	sition (Nam	e of her place	9)	Date		20c. Lo	cation - City	or Town, State	
<u>Ĕ</u>	Page ment a ant: If ury or		1		Θ	ring H				11-12	-05	Hun	tingto	n, WV	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show eny injury or other traumatic event, its Mudical Exam and marke collines at once.		21. Signat re Funeral Service Lie	fellmee	u					ral Ho . Hunt		n, W	V 2570	3	
-4. - 186			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus ly one cause on each	line.		1 1	1		cardiac or re	spiratory a	rrest,		Approximate Interval Between Onset and Death	
148	Physician		Immediate Cause (Final disease or condition resulting in death)	_a font	e vyo	cardia	id In	Paret	loy					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or a	is a consequ	ence of):									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Duá to (or a	is a consequ	ance of).									
	outed od ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.											
Ó,	cate be executed physicien and the burial-transit		resulting in death) Last		is a consequ	ence of):									
8760,	cate b physic the b	dicai		d											
Box 6	that the death certific ed by the attending p detached for use as	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregnar	ncv							Nad Data of a	to five	
Bo	atten d for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 4 ☐ Pregnant	2 🗌 Fetal	death 3	Ectopic pre					-	23d. Date of o Month	Day Year	
P.O.	t the c by the achec	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown											
Division of Vital Records, P	Se Lib	þ	Part II. Other significant condition  End Stay Rin	Scontributing to death	1.4	iting in the ur	1	use give Zpen v	nin Part I.		23e. Did t			to the cause of death?  Probably 4 □Unknown	1
O O	aw requir ss been si 2 should I	Completed	•			/		/			24a. Was		24b. Were	autopsy findings available o completion of cause of	)
œ —	The ate he page	Com									perto	rmed?	death	?	
/ita	clan: ertific ector,	Be (	25. Was case referred to medical examiner?	1			,			of Death (C					
<del>_</del>	Physi this c	. To	1 Yes 2 No 27. Manner of Death	The state of the s	tient 2 🗆 E	ER/Outpatien 28b. Time of			4 🗆 Nu				Other (S	pecify)	
on	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigat	28a. Date of In (Month, E	ay Year)	Injury	M	Ic. Injury Work	at ? ′es 2 □ l		Describe I	now injury	occurred		
<u>Visi</u>	Attending or death. ector: After by the fune	ifica	3 Suicide 6 Could no determine	t be 28e. Place of I	njury - At hor	me, farm, stre								Rural Route Number,	-
á	safter safter al Direct	Certification:	4   Homicide	building,	etc. ( <i>Specify,</i>	,					City or To	wn, State,	,		ij
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis and manner:	of examinati	vledge, death ion and/or inv	occurred a restigation.	t the time in my op	e, date an inion, deat	d place, and th occurred a	due to the at the time,	cause(s) date and	and manner place, and d	as stated. ue to the cause(s)	
	To the within 2 To the complete	ğ	29b. Signature and title of certified					License				29d. Date	e signed (Mo	nth, Day, Year)	
	a		/Vah				DO	0059	5120	)		nov	8 20	05	
2	I		301 Name and address of person with Child Palmer	no completed cause of	1	23a) (Type, Wen we	Print)	She	k 310	) Wa,	high.	, DC	2003	2	
36	Sta Registr		31. Date filed (Month, Day Year)	5 2005 <sup>32, Red</sup>	trai's Signati	Jr A	Jonale .	0			<i>y</i>				

			1 - For State Registrar	State of Maryland / Depa	artment of Health and rtificate of Death		2005 39120
	Physici		1. Decedent's Name (First, Middle, Last Baby Boy Wa	•		2. Date of Death Month NOV	Pay 29 Year 5 0330 M
	/Medic Examir		4a. Facility Name (If not institution, give Mercy Medical Co	street and number)	4b. City, Town, or Location of Dea		4c. County of Death Baltimore City
	Funeral Director		5. Social Security Number 1 6. Se		If Under 1 Year If Under 24 Hr. Months Days Hours Mir	(Month, Day, Y	9. Birthplace (State or Foreign
	ט		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo		11/29/2	10d. Inside City Limits
	the Mary 28a-f sh	ector	M D  10e. Street and Number	Baltimo	· · · · · · · · · · · · · · · · · · ·		1/2 Yes 2 □ No
	ath with	Funeral Director	212 Silver C	ourt	10f. Zip Code 21231	109	. Citizen of What Country?
980	72 hours after death with the Maryland natural', or itams 23a or 28a-1 show dical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces? If	Vas Decedent of Hispanic Origin? ( Yes, specify Cuban, Mexican, Pue ☐ Yes 2☐ No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	within ene. than "	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	e completed) (Give	ent's Usual Occupation kind of work done during most of wo OO NOT use retired)	orking 16	b. Kind of Business/Industry
Maryland 2	should be filed nd Mental Hygi marked other imatic event, I	To Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Mai	iden Sumame) WALLACE
	1 and 2 sho Health and Iem 27 Is m		19a. Informant's Name/Relationship (Ty	pe, Print) 19b. Mailin	g Address (Street and Number or R	. 0 . 1	ity or Town, State, Zip Code)
Baltimore,	pages 1 and of He out of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 14 ☐ Donation 5 ☐ Other (Specify)	iemovariiom state	sition (Name of atory or other place)		c. Location - City or Town, State
Balti	permit. Pages Department of I Important: If Ite any injury or of		21. Signature of Funeral Service Licens	Woodlawn	Name and Address of Facility Sterling Ashton S	Schwab Fune	odlawn, Maryland eral Home, Inc. asville, MD 21228
	Physician /Medical Examiner	Examiner	snock, or near failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reacing to immediate cause. Enter Underlying Cause (Disease or injury	a. Extreme prema  Due to (or as a consequence or):  Due to (or as a consequence or):	er the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed te has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a consequence of):  3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery  Month Day Year
<u>о</u> .	d by the etached	Physic	1 Yes 2 No 9 Unknown	9□ Unknown			
ords,	w requires the been signer should be d	by	Pan II. Other significant conditions con	tributing to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobace	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
al Record		Completed				24a. Was an autopsy performed 1 Yes 2	
Division of Vital	hys his	atlon; To Be	25. Was case referred to medical examiner?  1   Yes   2   No	ospital: 1 Junpatient 2 ER/Outpatient  28a. Date of Injury (Month, Day Year)  28b. Time of Injury	04	ath (Check only one)  lome 5  Residence  28d. Describe how in	e 6 □Other (Specify) njury occurred
Divis	tal or Attences after death	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, stre- building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	Hospi 24 hou Funer stely fill	edical	29a. Certifier (Check only one) 2 Medical Examin	cician: To the best of my knowledge, death her: On the basis of examination and/or inve and manner stated.	occurred at the time, date and place estigation, in my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
)	To the within To the Comple	¥	29b. Signature and title of certifier	WD	29c. License number		Date signed (Month, Day, Year)
				mpleted cause of death (Item 23a) (Type, P OI ST Paul Street Ba		02	
	Sta Registra		31. Date filed (Month, Day, Year) DEC 0 5 2005	32 Registrar's Signature	el, s		

		•	1 - State Amend Item	State of Maryla 25a, 25, 26, 2	nd / Dep <b>7 per</b> C	artment of	Health and 12/05/05	d Mental Hy 5 <b>đhb</b>	giene 05	39121
37	Z .		1. Decedent's Name (First, Middle, L.	ast)				2. Date of De	eath Day Yea	3. Time of Death
ALC: NO	Physici: /Medic	_	Bernice W	J:15017				Nov	3 200	More in the cold
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Town,	or Location of De	eath	4c. County of De	eath
No.		2	University of M	anyland Medical	Center		incre			
b	Funeral		5. Social Security Number 6.	Sex 7. Age (In yr. 1 ☐ M 2 ☐ F	s. last birthday, 83 Yrs.	Months Day		fin. 8. Date of Bir (Month, Da Sep 1,	th 9. E	Birthplace (State or Foreign Country)
2	Director		210-12-7113	12.00 294.	OJ TIS.			Sep 1,	1922 Mar	ryland
	and w	-	Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or L	ocation				10d. Inside City Limits
	Maryl f ehc	5	MD Anne Ar	rundel Ar	napoli	S				1 XYes 2 □ No
	28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	with be or		22 Parole Street			21401			United Sta	ates
	n 72 hours after death with the Maryland "natural", or iteme 23a or 28a-f ehow kolcal Examinar must be notilled at	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No		merican Indian,
10	riter	F	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No				uerto Rican, etc.)	Black, W	hite, etc.
036	urs a	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 📉 N	o Specify:		Specify: Black	
21215-0036	72 ho	Completed	15. Decedent's E (Specify only highest g.	Education		edent's Usual Occ e kind of work don		workina	16b. Kind of Busine	ss/Industry
21	c * 3	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use reti	red)		Domestic	
2	filed wi Hygien ther th	ő	12		Home	Maker			L	
Maryland	ges 1 and 2 should be filed within tof Health and Mental Hygiene. If Item 27 is marked other then or other traumatic event, the Me	Be	17. Father's Name (First, Middle, Las	it)					, Maiden Sumame)	
yla	should ind Men marke umatic	၉	James Larkins				Gladys			
lar	2 sh and ls m		19a. Informant's Name/Relationship			_		<i>Rural Route Numb</i> apolis, N	er, City or Town, State	e, Zip Code)
	1 and 2 Health tem 27 I		Shonnette Blake/			osition (Name of	CC. AIII	Date	20c. Location - City	or Town Clata
Baltimore,	Pages 1 ar nent of Heal ant: If Item? ury or other		20a. Method of Disposition 1   Burial 2 □ Cremation 3					Nov 10		
Ë	Pa ant:		4 □Donation 5 □ Other (Spec	(v)	rownsy	lle Veter		2005		unsville
3al	permit. Departr Importe any inju		21. Signature of Fyn ral Service Lic	17-11. A	2	Miller S	ress of Facility Metropo	olitan Cha	apel	
	70 F 6 0		/ While // W	W My	-			re Annap	· · · · · · · · · · · · · · · · · · ·	Approximate
			23a. Part 1. Exter the disease, or conshock, or heart failure. List only	mplications that caused the de y one cause on each line.	ath. Do not er	iter the mode of d	ying, such as car	diac or respiratory a	irrest,	Approximate Interval Between Onset and Death
И	Physician		Immediate Cause (Final disease or condition	a hypoxic	a					
	/Medical Examiner		resulting in death)	Due to for as a cons	equence of):					
У	S. S.	_	Sequentially list conditions,	b. Airway	obstri	uction				
	si ed	Examiner	Sequentially list conditions, Tary, loading to mine dials cause. Enter Underlying Cause (Disease or injury	Light suppressions	equence our					
	and and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a cons	e uenc = f):					
8760,	cate be executed oblysicien and the burial-transit	E I								
87	phys the	dicai		La trache	o A ATTACK	, α				
9 X	The law requires that the death certificate be executed ate has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, outcome of preg	nancv				23d. Date of	delivery
Вох	etten for u	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fo 4☐Pregnant at time o	etal death 3	☐Ectopic pregnar ☐ Other (specify)			Month	Day Year
0	that the de ed by the detached	ysic	1 □ Yes 2 ☑/No 9 □ Unknown	9□ Unknown						
٥	that the ed by detac		Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying cause	given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ds,	uires tha signed l	d b	COPD					1 🗆	Yes 2 □ No 3 □	Probably 4 Dunknown
Ö	w requir been si should	Completed by				11		24a. Was	an 24h Were	autopsy findings available
3ec	has has	E E	chanic track	neostony an	dvent	Mataci	Equi em	auto	nsv nnor	to completion of cause of
of Vital Records,	ding Physicien: The I h. After this certificate ha funeral director, page								2 <b>X</b> No 1 Y	'es 2□ No
V.	icier certif recto	Be	25. Was case referred to medical examiner?	Hospital:			)thor	Death (Check only		
o	Phys this ral di	. To	1 Tes 2 No  27. Manner of Death	1 Lanpatient 2	28b. Time	S			idence 6 Other (S	pecity)
L	Jing After funer	lon	1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	V	ork? □ Yes 2 □ No	250. 250050	,ary obtained	
Division	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 □ Could not	be 290 Place of Injury . Al	home, farm, s			28f. Location (	(Street and Number or	Rural Route Number,
S	after Dire	erti	4 Homicide determine	building, etc. (Spe	icity)	,,	-	City or To	wn, State)	
	ppitel ours nerel filled		29a. Certifier 1 Certifying !	Physician: To the best of my k	nowledge, dea	ith occurred at the	time, date and p	lace, and due to the	cause(s) and manner	as stated.
	24 h 24 h Fur etely	Medical		aminer: On the basis of exam and manner stated.						
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director,	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)
	> p== ()		100	LUN		160	1041-		Nov 21,	2006
			30. Name and address of person wh	o completed cause of death (I	tem 23a) (Type	e, Print)	- 10		100001	
			Ci.	adec 225	aceen	e S+ 7	BeHima	e, MD	21322	
15	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature A	Sid.		)		
	Regist		DEC 0 5 200	D proper so	S. S. Sand					

State of Maryland / Department of Health and Mental Hygiene Amend Item 23a per Dr., G849, 12/05/05/dbb of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Ollie Mae Watson October 01 2005 3:40 am /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Silver Spring Holy Cross Rehab Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year)
Aug. 24, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 KF Yrs. 444-26-5774 88 1917 South Carolina Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylend Depertment of Haalth and Mentel Hygiene. Important: If tem 27 is marked other than "naturel", or hema 23s or 28s-f show any fujury or other traumatic event, the Medical Examinar must be notified at angles. 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 X Yes 2 No Director MD Prince George's College Park 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 5960 Westchester Park Drive #T1 20740 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🖾 No Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unk. Dietician Federal Government 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Luke Fisher Bell Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Judy Watson/Niece 1157 5th Street NE Washington, DC 20002 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial Park 10/8/05 4 ☐ Donation 5 ☐ Other (Specify) Landover, MD 21. Signature of Funeral Service Licenses 22. Name and Address of FacilityJohnson and Jenkins Funeral Home 716 Kennedy Street NW Washington, DC 20011 23a. Per 1. Enter the disease, or compilertions that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical RENAL FAILURE Examiner Due to (or as a consequence of): Examiner Hypertension attanding physicien and for use es the buriel-transit The few requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of) has been signed by the gas 2 should be datached Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes an autopsy performed? 24b. Were autopsy findings Completed available prior to completion of cause of death? pega 1 Typs 2 No 1 ☐ Yes 2 ☐ No cartificata or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🛣 No ၉ this After this funeral c 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. 28d. Describe how injury occurred Certification: Injury et Work? 1 Maturel 5 Pending investigation Injury To the Hospital or Attendir within 24 hours efter death.

To the Funeral Director: At complataly filled in by the fu death. 1 Tes 2 🗆 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical 1 Certifying Physicien: To the best of my knowledge, death occurred et the time, date end plece, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred et the time, date and placa, and due to the cause(s) and manner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25348 October 5, 2005 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Marcia P. Goldmark, MD 15020 Shady Grove Rd. suite 300 Rockville, MD 20850 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State Registrar **DHMH 16 Rev 6/95** 

			1 - For Stata Registrar	itate of Maryland /	Depa		of He	alth and	Mental Hy		-	39123
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)  John M. Weldon  4a. Facility Name (If not institution, give stree  Gilchrist			4b. City, To		ocation of Deat	2. Date of De Month Decembe	er 3, 2	2005 unty of Death	3. Time of Death 6:40 a M
	Funeral Director	4	5. Social Security Number 219-26-7099 6. Sex 1XI M  Usual Residence of Decedent	7. Age (In yrs. last b	Yrs.	If Under 1 Months [	Year It	Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da Jan 26	th.		place (State or Foreign ntry) I and
	I be filed within 72 hours after death with the Maryland intal Hygiene. •d other then "natural", or Itame 23a or 28a-f show cevent, the Medical Exactional round be rectified at	Funeral Director	Md. 10b. County Baltimore  10e. Street and Number  5232 Millfield Rd.	10c. City, To	or Lo		ode 212:	37		10g. Citizen	of What Cour	•
-0036	hours after deal	b		Was Decedent Ever in U.S. Armed Forces? 1XIYes 2 □ No If Yes, Give Year or Dates:	1	Vas Deceder f Yes, specify	nt of Hispa Cuban, ! No S	anic Origin? (S Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	Spe	Race - Americ Black, White, ecify: Whi	ean fndian, etc. te
acon-91212 pu	d tal	Be Completed	(Specify only highest grade co	college (1-4or 5+)	(Give .	perty	done duri retired) Manac	ng most of wor Jer . Mother's Nar	ne (First, Middle,	Real Maiden Sun		•
e, maryiand	f and 2 should fealth and Me om 27 le mark ther traumation	To	Stewart G. Weldo 19a. Informant's Name/Relationship (Type, Mrs. Erika Weldon/ W 20a. Method of Disposition	ife 19	523		lfiel		rine St ral Route Numbe Baltimor Date	e, Md.	wn, State, Zip 21237	
Baitimore,	permit. Pages Department of Himportant: If Ite eny injury or of once.		1 Burial 2 Cremation 3 Rem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Strvice Ucensee	oval from State	<i>ор</i> S	ervice Name and A Ruck	er place) Co. Address o	f Facility Son Fund	-05 eral Hom	Towso	on - City or To	wn, State
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ons that caused the death. Do ause on each line.  MUITINE My  Due to (or as a consequence	relo	er the mode o	YORK of dying, s	uch as cardiad	OWSON, M	d. 212 rest,	· · · · · · · · · · · · · · · · · · ·	Approximate Interval Between Onset and Death
08/00,	ate be executed hysicien and hysicien and ithe burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence								
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necords, P	The faw requires that the death ate has been signed by the atte page 2 should be detached for	Completed by Pr	Parl II. Other significant conditions contrib		in the un	derlying caus	se given ir	Part I.	1 Y	es 2 No	3 🗆 Proba	e cause of death?  ably 4 Conknown  osy findings available opletion of cause of
ol vita	ding Physician: h. After this certificatuneral director, i	25. Was case referred to medical examiner? 1								2 No 16) ence 6 20	1 ☐ Yes :	etorice
S	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	edical Certification:	3 Suicide 4 Homicide 6 Could not be determined 2  29a. Certifier 1 S Certifying Physicia	Be. Place of Injury - At home, for building, etc. (Specify)  n: To the best of my knowledg. On the basis of examination and	e. death	occurred at t	he time d	late and place	28f. Location (S City or Tow	n, State)	mannor as sta	atod
í	To the I	Medi	29b. Signature and title of certifier	in one of the original original original original original original original original original original origin		29c. Li	cense nui	mber		9d. Date sign	ned (Month, D	Day, Year)
	Sta Registr	_	21 Date Glad (Month Day Vend)	ated cause of death (Item 23a)  I NOTTH Chay (	2 2	it:	Tous	on M	0 212	.04		

6:40 am

John

State of Maryland / Department of Health and Mental Hygiene 0 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year DECEMBER 1 2005 WENDY WAGNER 4:57 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FUTURE CARE CHERRYWOOD REISTERSTOWN BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 212-50-54 Director 07/16/1952 53 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo BALTIMORE REISTERSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a 12020 REISTERSTOWN ROAD 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ▼ Divorced WHITE "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) COMPUTER PROGRAMMER N.A.S.A. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) eges 1 and 2 should be fill nt of Health and Mental H LOUIS WAGNER **ESTHER** FRIMET 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9773 GR0FFS MILL DRIVE APT. #207

OWINGS MILLS MD 21117

ace of Disposition (Name of Date 200c. Location - City or Town, State 19a. Informant's Name/Relationship (Type, Print) ESTHER WAGNER / MOTHER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Peges 1 1 Burial 2 □ Cremation 3 Removal from State
4 □ Donation 5 □ Other (Specify) permit. Pege Department of Important: If any injury or UNITED HEBREW 12/02/2005 STATEN ISLAND, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Total 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Lun, Concer Immediate Cause (Final disease or condition resulting in death) Metrin Physician mo /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Each of the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 0 in the past 12 months? Day 4☐Pregnant at time of death Year 5 Other (specify) o detached 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown eted peen 24b. Were autopsy findings available prior to completion of cause of death? Comple 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital : After this certification : After this certification : 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Vursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 1 Natural 5 Pending Injury To the Hospitel or Attendi within 24 hours after death.
To the Funerel Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ros J. Mm, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cento Do Reinfronts- MI L. Mois 1/4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 5 2005 Registrar

		1 - For State Registrar	State of Ma	aryland / De	epartment of Certificate of	Health and Death		giene 05	39125
Physic /Medi	cal	Decedent's Name (First, Middle, L.     Aa. Facility Name (If not institution, gi	Keith	Ander		or Location of D	2. Date of De Month	Day Ye	5 5:30PM
Examir Funeral Director	ner	FOREST GLE  5. Social Security Number 6.	N NURS	MG HOM e (In yrs. last birtho	(ay) If Under 1 Year Months Day	VER SI	PRING Hrs. 8. Date of Bir (Month, Da	MON th 9.	Birthplace (State or Foreign Country) Washington, DC
p .	tor	Usual Residence of Decedent  10a. State 10b. County	omery	10c. City, Town o	r Location Lver Sprin	ng	OCCOBE	2,190/	10d. Inside City Limits 1X Yes 2 □ No
with the 3s or 28s	il Director	10e. Street and Number  2700 Barker Str	eet	J	10f. Zip Code			10g. Citizen of What	•
ife, INAI yial to ZIZIO-000 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23e or 28e-1 show other traumatic event, the Medical Evantinat must be notified at	by Funeral	11. Marital Status  1   Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Tyes 2 11 Yes, Give Year or Dates:	Ever in U.S.	13. Was Decedent of If Yes, specify Cu 1 Yes 2 N		? (Specify Yes or No uerto Rican, etc.)		American Indian, Vhite, etc.
d within 72 hoggiene.	Completed	15. Decedent's Eigenentary/Secondary (0-12) 12th grade		(C	ecedent's Usual Occ Give kind of work don fe. DO NOT use retii Carrier	e during most of red)		16b. Kind of Busine DHL World Express	,
al yial to should be file and Mental Hy marked oth umatic avent	To Be (	17. Father's Name (First, Middle, Las Charles Edwar		n			Name (First, Middle  Mae Ja	, Maiden Sumame) ckson	
permit. Pages 1 and 2  permit. Pages 1 and 2  Department of Health a  Important: if item 27 is  any injury or other tra  once.	er	Denise Lorraine  20a. Method of Disposition  1	Removal from State  (fy)  Prise  Inplications that caused yone cause on each lin  Difference to form the cause of the cause on each line  Difference to form the cause of the	20b. Place of D cemetery, National	isposition (Name of crematory or other p.  al Harmony  22. Name and Add  R. N. H  600 Ken  enter the mode of delication.	Memoria Memoria Jess of Facility Corton Comedy St. Jying, such as car	v.15,2005 al Park ompany Moreet,N.W.	Landover, rticians, Washingto	Maryland Inc. pn,D.C. 20011 Approximate Interval Between
The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examin	la any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d	a consequence of)					
the death cery the attending ached for use	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of Month	delivery Day Year
w requires that the death certificate signed by the attending plant is a should be detached for use as t	b	Part II. Other significant conditions  1. Wasting	2. An.	emia	3. dia	rhea			e to the cause of death?  Probably 4 Munknown
VII.dl nec ician: The law sertificate has b ector, page 2 st	e Completed	4. Mycobac 5. Esophago 25. Was case referred to medical	•	Avium idiasi.	Compl S		24a. Was autoperformed autoper	prior death of the prior death o	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
VISION OF VITA Attending Physician: or death. ector: After this cartifica by the funeral director.	To B	examiner? 1 Tyes 2 No  27. Manner of Death	Hospital: 1 Inpatie	ent 2 ER/Outpa	e of 28c. In	ther: 4 Vilursin	ng Home 5 Resi	dence 6 Other (5	Specify)
5 # 5 E	ertification:	1 Matural 5 Pending 2 Accident 3 Suicide 6 Could not 4 Homicide determine	be 390 Blood of Ini	ury - At home, farm		□Yes 2□No	28f. Location (. City or To		r Rural Route Number,
the Hospital hin 24 hours the Funeral npletely filled	edical C		Physician: To the best aminer: On the basis of and manner sta	f examination and/o					
To th within To th	Me		lly, mo		D	4 3/2/		29d. Date signed (M	onth, Day, Year)
- (2)	ate	30. Name and address of person who NURUL CHUW): 31. Date filed (Month, Day, Year) NN1/ 9 1 200	FURY, MD	death (Item 23a) (Ty 25/4/ K ar's Signature	rpe, Print) ING CHA,	RLES W	DAY : BET	HESDA,	MD 20814

			For State Registrar	State of Maryland /		rtment of Healf tificate of Dea		ntal Hygien Reg. N	OOO	39126
			Decedent's Name (First, Middle, La.	st)	-		2	. Date of Death	ay Year	3. Time of Death
	Physici /Medio		Ethel R	. Airing					14 20	05 5:35₽ <sup>M</sup>
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Local	tion of Death	4	c. County of Dea	ith
			4023 Baptist			Taneyto			Car	
	Funeral Director		5. Social Security Number 6. S	ex 7. Age (In yrs. last b ☐ M 2](C) F	Yrs.	Months Days Hor	nder 24 Hrs. 8 urs Min.	Date of Birth (Month, Day, Yea		nthplace (State or Foreign ountry)
			218-32-6720 Usual Residence of Decedent					8/14/1	935	PA
	ehow		10a. State 10b. County	10c. City, To			-			10d. Inside City Limits
	Ba-f-	cto	MD Carr	011	Tane	ytown				1 ☐ Yes 2X No
	or 2	드	10e. Street and Number			10f. Zip Code		10g. C	itizen of What C	
	• 23e	al		ptist Rd. 12. Was Decedent Ever in U.S.	12.14	21787	o Original (Consider	Ver er No	US.	
21215-0036	be flied within 72 hours efter death with the Maryland tiel Hygiene. Id other then "naturel", or Itame 23e or 28e-f ehow event, the Midical Examinar must be mailied at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Tyes 2 Tylo  If Yes, Give  Year or Dates:	lf	/as Decedent of Hispanion Yes, specify Cuban, Med  ☐ Yes 2 No Specify No Specify	xican, Puerto Ric	ean, etc.)	Black, Whi	
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2	DEL	ខ	1 () 17. Father's Name (First, Middle, Last)		Sea	mstress	dath arts bloss //	Set	wing f	actory
Maryland	d be fi	Be				18. N				
Ž	hould d Me mark matic	ဥ	David A. Wa  19a. Informant's Name/Relationship	rner Type Print) 19	9b Mailine	Address (Street and Nu	A [] [] L	e B. C1	or Town State	Zin Code)
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Baltimore,	les 1 and 2 should be file of Heelth end Mentel Hyg If item 27 le marked othe or other traumatic event,		20a. Method of Disposition	camat	of Dispos	ition (Name of atory or other place)	Date	20c. l	_ocation - City or	Town, State
Ë	permit. Peges Department of I Important: If it any Injury or o		1 SpBurial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		C Cemeter	v 11/1	8/05 T	aneyto	wn, MD
alt	permit. Departrimports Imports any Inju		21. Signature of Funeral Service Licen			Name and Address of F	acility		1	7340
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	Physician /Medical Examiner	er	23a. Part1. Enfer the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence	e = -)					Interval Between Onset and Death
	nsit	를	cause. Enter Underlying	27						
Ć,	icate be executed physicien end s the burial-trensit	Examin	that initiated events resulting in death) Last	Due to (or as a consequence	e of):					
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P.O. Box	Physician: The law requires that the deeth certific this certificate has been signed by the attending It director, page 2 should be deteched for use as	Physician/M	23b. Wes decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	res thet igned b be dete	by Pi	Part II. Other significant conditions of		in the un	derlying cause given in P	Part I.	23e. Did tobacco	use contribute to	the cause of death?
ğ	w require been sig should b		None	Known				1 ☐ Yes 2	Po 3□P	robably 4 Unknown
of Vital Records,	The law requiete hes been page 2 should	Completed						24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ N	prior to death?	utopsy findings available completion of cause of 2 No
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Line and the least of the least			Place of Death (C	The second secon		
5	Physic this o	၉	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient . Time of	3 DOA Other: 4		5 Residence		city)
5	D = 0	틸	1 Natural 5 Pending	(Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes 2		. Describe how inju	ну осситеа	
Division	il or Attending effer deeth. Director: Aftei d in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		farm, stre			Location (Street a City or Town, Stat		urai Route Number,
	To the Hospital or Attendii within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death and/or inve	occurred at the time, datestigation, in my opinion,	e and place, and death occurred	due to the cause(s at the time, date an	s) and manner as id place, and due	s stated. to the cause(s)
	To the complex	Σ	29b. Signature and title of certifier	coit		29c. License numb		29d. Da	ate signed (Mont	
	10			L. M.D. 555 S. C.	ente	- St. Wa	רעהי החלצ	ier, md.	2115	7
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature						
PL	Registr	ar	NOV 1 6	2005 Thomas D	1 /	park				

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 1840 WILFORD ELIJAH AYRES November 12. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Snow Hill Nursing & Rehab. Center Worcester Snow Hill If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F 80 July 4. Maryland Director 218-20-8924 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County 28e-f show Examinent ust be notified at 1 Yes 2 No Maryland Worcester Snow Hill Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 501 Maple Street, Apt. 403 21863 USA or items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3 ☐ Widowed 4 Divorced BLACK "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) then Elementary/Secondary (0-12) Farming 9th laborer and Mental Hygicals Is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Avres Effie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: If Item 27 Is any injury or other trav. 2005. Lorenzo Collick/son 10415 Harrison Road - Berlin, Maryland 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Wesley Ch. Ceme. 11/19/2005 Snow Hill, Maryland 21. Signature of Funeral Service Lie 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 105 JOLLEY MEMORIAL CHAPEL 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL **Physician** END STAGE /Medical Due to (or as a consequence of): Examiner ACCIDENT CEREBRO VASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed and use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month jo in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No. P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 2 100 2 No 1 Yes certificate Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After | or Attanding 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Diractor: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide after To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 14/13/2005 00062172 Jaly. MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POCOMOKE CITY 21851. 1604 MARKET STREET MD SATYAL, MU SMARAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 Registrar

**ORIGINAL** 

Christia 05-07729		е.	Aceituno Please Amend/Unpend	Type or Prin	it in Blac a,27,28	k Inde a-f,p	ible Ink erME,G8	Ensure Al	I Copies 3-05 I I	Are L	egible.	
crn		-	For State Registrar	Olato of Mic	ary tarto 7		cate of			Reg. No.		39128
**	Physicia	n	1. Decedent's Name (First, Middle, L	ast) Christia Andr	n Andre	y Ace	ituno /	humada	2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al -	4a. Facility Name (If not institution, gi					r Location of Death	Novemb		5, 2005 County of Death	11:23 A M
Co	Examine	er 4	Shady Grove Adve		ital		Rockvi			I	Montgom	ery
9	Funeral		Social Security Number     6.	Sex 7. Age	e (In yrs. last bi		Under 1 Year onths Days 6 20	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	9. Birth	nplace (State or Foreign untry)
9	Director		NONE Usual Residence of Decedent						4/26	/ 200.	) Ma	ryland
	permit. Pages 1 and 2 should be lied within 72 hours after death with the maryanu Department of Health and Mental Hygiene. Important: if tiem 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Exerciper must be notified at once.	Director	MD Montg	omery	10c. City, Tow Gern	nanto	wn					10d. Inside City Limits 1 ☐ Yes 2 No
	3a or 24	i Dire	10e. Street and Number 13061 Millh	ouse Cour	t	1	Of. Zip Code 2078	4			sen of What Co SA	untry?
1	tems 2	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was	Decedent of H s, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0- 1	4. Race - Amer Black, White	
036	al', or li	þ	1 ⚠ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates:	No	128	Yes 2□No	Specify: Per	uvian		Specify: W]	nite
5-0	naturi digital	Completed	15. Decedent's (Specify only highest g	Education trade completed)	16a	(Give kind	s Usual Occup of work done	pation during most of work		16b. Kin	nd of Business/	ndustry
121	within lene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5	5+)		one	a)		:	none	
and 2	ontal Hygi wad other c event, I	To Be Co	17. Father's Name (First, Middle, Las Orson Aceitu					18. Mother's Nam Melc	e (First, Middle odie A	huma	Sumame) do	
Baltimore, Maryland 21215-0036	ith and M 27 is mar r traumati	-	19a. Informant's Name/Relationship Melodie Ahum			b. Mailing A	ddress (Street	and Number or Aur lhouse C	al Route Numb	oer, City or Germ	Town, State, Z antown	ip Code) 1, Md20784
ore,	Jes 1 a 1 of Hea 1f item or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	☐Removal from State	1	ery, cremato	ry or other pla	сө)	Date		cation - City or	
Ħ.	iff. Pag intment injury		4 □ Donation 5 □ Other (Spec 21. Signature of the Paral Service Lio	city/ -	Gate		Heave	n 11/22 SSRTNALDI		_		oring,Md
Ва	Departme Importan any injur		Valey Dl	relt		924	1 Col	umbia B	lvd.Si	lver	Sprin	ig,Md20910
70	Physician /Medical Examiner		23a. Part 1. Enter the disease, or co shock, or hear failure. List on fmmediate Cause (Final disease or condition resulting in death)	a Sudden		ained		ng, such as cardiac		arrest,		Approximate Interval Between Onset and Death
,8760,	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a consequence of):  Due to (or as a consequence of):							
P.O. Box 68760	the death certificing the the attending phone of the death of the as the check as the content of	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 ☐ Fetal deat		opic pregnanc her (specify) _	у	gr.	2	3d. Date of deli Month	very Day Y <i>e</i> ar
ds, P	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions	s contributing to death b	out not resulting	in the unde	flying cause gr	ven in Part I.	1	tobacco us		the cause of death?
		Completed							per	s an opsy formed? 2 \( \sqrt{No}	24b. Were au prior to death? 1 X Yes	topsy findings available completion of cause of
Vita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?	Hospitaf:			Ot	26. Place of Deather:				
of	g Phys er this eral dii	n: To	1 ☐XYes 2 ☐ No 27. Manner of Death	Fred ate of fnju (Month, Da	ent 2 ER/C	Time of Injury	28c. Inju Wo	4   Ivuising in			y occurred <b>UI</b>	
sion	ending eath. or: Aft	atio	1 □ Natural 5 □ Pending 2 □ Accident investigat 3 □ Suicide 6 【X Could no	ion 11-16-05	7:	15 A	M 1	]Yes 2. TNo				
Divi	or Att after d Direct in by	Certification:	3 ☐ Suicide 6 <b>X</b> Could no 4 ☐ Homicide determina	building, el	jury - At home, ! lc. <i>(Specify)</i> at resi		factory, office		City or To	own, State)	13061 M	ral Route Number, Lillhouse Ct.
_	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: Attent his certifical completely filled in by the funeral director,	edical C	(Check only 2 Medical Ex	Physician: To the best	of my knowledg	an dooth as	curred at the tagation, in my	ime, date and place, opinion, death occur	German and due to the red at the time	a caucale)	and manner as	stated. to the cause(s)
	o the Hithin 24 o the Formplete	Medi	one) A  29b. Signature and title of certifier	and manner st	ated.			se number			e signed (Monta	
	Co T S		1 Tabrill	Cel Alex			0	.C.M.E.		Novem	ber 17,	2005
			30. Name and address of person w	no completed cause of o	death (Item 23a	1) (Type, Pri	nt)	reet, Bal	timore,	Mary	land 21	.201
6	Sta Registi		31. Date filed (Month, Day, Year)	2005 32. Alegisti	rar's Signature	Apa	le					

		•	For State Registrar	St	ate of Ma	arylanc		artment of H		and M		giene Reg. No.	005	39130	
	Physici	an.	1. Decedent's Name (First, M	iddle, Last)							2. Date of De	ath Day	Year	3. Time of Death	_
	Physici Medic/	al	Evelyn Luc	y Botts							11	13	05	9:00 A M	I
	Examin	er	4a. Facility Name (If not instit		t and number)			4b. City, Town, or		of Death			County of Dear		
			11609 Roulad 5. Social Security Number	e Place	7 40	e (In yrs. la	st hirthday)	Clin	Iton If Under	24 Hrs.	8. Date of Bir			Georges	
1	Funeral Director		218-07-7027 Usual Residence of Deceder	1 🗆 M		90	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da 06-18	19, Year) -15	9. Bill	thplace (State or Foreign puntry) MD	n.
	land ow		10a. State 10b. Co			10c. City,	Town or Lo	cation						10d. Inside City Limits	
	Many a-f sh	tor	MD Pri	nce Geo	roes		Clin	ton						1 XYes 2 □ No	)
	or 28	Funeral Director	10e. Street and Number	nce deo	-5		9111	10f. Zip Code				10g. Citiz	en of What Co	ountry?	
	23a	Ta	11609 Roula	le Place	2			2073					ed Stai	tes	
	tema tema	une	11. Marital Status	A	Vas Decedent rmed Forces?		3. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Ori n, Mexicar	gin? (Spe	cify Yes or No Rican, etc.)	)- 1·	<ol> <li>Race - Ame Black, Whit</li> </ol>		
36	rs aft	by F	1 ☐ Never Married 2 ☐ 3 ☐ Widowed 4 ☐ Divo	16	☐ Yes 2 🔯 l f Yes, Give ∕ear or Dates:	No		1 ☐ Yes 2 🔀 No	Specify:			5	Specify: Bla	ack	
Š	within 72 hours after death with the Maryland ene. than "naturel", or iteme 23e or 28e-f show fre Madical Exariliner issal by mullified at	ted	15. Dece	dent's Educatio	n		16a. Dece	dent's Usual Occupa	ation			16b. Kin	d of Business/	/Industry	
21215-0036	thin 7	Completed	(Specify only n Elementary/Secondary (0-	ghest grade cor 2)	npietea) College (1-4or t	5+)	life.	kind of work done of DO NOT use retired	during mos	t of worki	n <i>g</i>				
7	yglen yglen ver th	Con	12				Н с	ousewife					Home		
and	be fill d off	Be	17. Father's Name (First, Mic	dle, Last)							(First, Middle	, Maiden S	Sumame)		
3	d Mer narke natic	T <sub>o</sub>	Edgar Tate  19a. Informant's Name/Rela	inachin (Tuna 1	Drint)		10h Mailie	ng Address (Street a			Kelly	0/1	T 01-1-	7-0-11	
Maryland	id 2 si		Robert Botts		runy			9 Roulad						zip Code)	
ē,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show any injury or other traumatic event, the Medical Exacting Total by neithing at ance.		20a. Method of Disposition			20b. Pla	ace of Dispo	sition (Name of	-		ate		ation - City or	Town, State	-
altimore,	Pages ent of nt: If i		1 🕅 Burial 2 □ Cremat 1 □ Donation 5 □ Other		val from State	ŀ	-	natory or other plac	6)	11 1	0.05	0		ir.	
alti	partm partm porta y inju		21. Signature of Funeral Ser				COLD	Memorial  . Name and Addres	s of Facilit		8-05			ervices	
m	8 8 E 8 8	l la	Eric &	Stre	ikl	ans	6	500 Allen	town						
П			23a. Part1. Enter the diseas shock, or heart failure.	e, or complication	ons that caused luse on each li	d the death. ne.								Approximate Interval Between	
	Pnysician	1	Immediate Cause (Final disease or condition	а.	Pancre	atic	Cance	r						Onset and Death	
	/Medical Examiner		resulting in death)		Due to (or as	a conseque	ence of):								
	ZAGIIIIIO	<u></u>	Sequentially list conditions, if any, leading to immediate	b	Due to (or as	2 000590116	ence of):								_
	ned nsit	nine	Cause. Enter Underlying	<	D46 to (01 43	a conseque	61106 01).								
Ć.	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	С.	Due to (or as	a conseque	ence of):								
8760,	death certificate be executed e attending physician and of for use as the burial-transit			d.											
9	ntifica ng ph as th	Medi	IF FEMALE:												
Вох	eath certific attending pl	an/	23b. Was decedent pregnar in the past 12 months?		f yes, outcome 1 □Live birth			Ectopic pregnancy				23	d. Date of del	ivery Day Year	
O.	the deay the a	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant a 9□Unknown	t time of dea	ath 5□	Other (specify)					WORT	Day	
Δ.	- 0 00		Part II. Other significant cor	ditions contribu	uting to death b	out not resul	lting in the u	nderlying cause give	en in Part I.		23e. Did t	obacco us	e contribute to	the cause of death?	
Vital Records,	Se P6	ed by	Seizure Di								1 🗆	Yes 2□	lNo 3□Pr	obably 4 🔀 Unknown	l
000	aw requir is been si 2 should	Completed									24a. Was		24b. Were au	itopsy findings available	,
Ä	و تـ و	mo									auto perfo	rmed?	death?	completion of cause of 2 No	
ita	ilcian: Th certificate rector, pag	Bec	25. Was case referred to me examiner?	dical					26. Place	of Death	(Check only				_
of V	Physician: this certific ral director.	2	1 ☐ Yes 2 🔀 No	Hospi	1 L Inpatie		R/Outpatier	- I want to be a second	4 LI NU	rsing Hor	ne 5 <b>X</b> Resi	dence 6	□Other (Spec	city)	
n o	ing After une	lon:	27. Manner of Death 1   Natural 5 □ Pe	nding	8a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	Work		i.	28d. Describe	how injury	occurred		
Division	I or Attending after death. Director: Afte	lcat	3 ☐ Suicide 6 ☐ C	estigation uld not be	Re Place of Ini	iury - At hor	ne farm str	M 1 1	Yes 2 🗆	_	28f. Location (	Street and	Number or Ri	ıral Route Number.	_
Ď	after after I Direct	Certification:	4 Homicide	termined 4	building, et	c. (Specify)	)	eet, factory, office		'	City or To	wn, State)	realized of the	nar noble Number,	
	To the Hospital or At within 24 hours after o To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 X Cer (Check only 2 Med	ical Examiner:	n: To the best On the basis o and manner st	f examination	vledge, deatl on and/or in	n occurred at the tim vestigation, in my op	ne, date an pinion, dea	d place, a th occurre	and due to the ed at the time,	cause(s) a date and p	nd manner as place, and due	stated. to the cause(s)	7
	To the within 2. To the complet	Me	29b. Signature and title of ce	rtifier	M·	1	1	29c. License	number			29d. Date	signed (Mont)	h, Day, Year)	
)			Mun	Il.	Kuc	tur	Astr	H0060	781			11	/16/05		
12	(4)		30. Name and address of pe	dson. M			, , .			ole H	ills.		0735		
	Sta Registi		31. Date filed (Month, Day, NOV 1	8 2005	Registr	ar's Signati									

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 15, 2005 Marion Lucille Bentley 3:18 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 72 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🔀 F Director 214-32-7550 12/12/32 Wash.,D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Iteme 23a or 28a-f ehow the Medical Examinar must be notified at Md. P.G. Temple Hills XX Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 4871 St. Barnabas Road 20748 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: American Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: à 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Bureau of Engraving and Elementary/Secondary (0-12) College (1-4or 5+) Printing employee U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any liqury or other treumatic event potes. Be James Thomas Day Martha Spriggs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen F. Davis/Daughter 10402 Jib Court, Cheltenham, Md. 20623 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ¥2 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/23/05 Landover, Maryland Harmony Mem. Park 21. Signature of Funeral Service Licensee Page 22. Name and Address of Facility & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS 11 DAYS /Medical Due to (or as a consequence of): Examiner INFECTED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last SACKAL DECUBITUS Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760, by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery ned by the ettend deteched for us 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown H YPERTENSION THROMBOSIS Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DISEASE END STAGE RENAL Be 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1-Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral Completely filled in 12 Certifying Physician: T, the basi of my knowledge, death conumed at the time, date and plane, and due to the causa(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifie (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) ela enha ND 16TH NOVEMBER D0016116 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PISCATAWAY ROAD 750 2. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 1 2005 Registrar

# Amended Items 25 & 27 Per M.E. 11/17/2005, Carroll County, wj1 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** November 13 2005 David Michael Bishop 3:00 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Sykesville Continuum Care of Sykesville Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth Dec 08 1965 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F 39 218-94-3001 Yrs. MD Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r items 23a or 28e-f show therroast be notified at 1 to 2 No Director MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 7309 Second Avenue USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. sm 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Mo Specify: other treumetic event, the Medical Example Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Mechanical Designer PACE, Inc 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Betty I. Leister Hoyt M. Bishop 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health as Importent: If Item 27 is any injury or other treu <u>once.</u> Lisa Bishop/wife 723 Rainbow Drive Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11/17/2005 1 XBurial 2 Cremation 3 Removal from State Evergreen Memorial Gardens Finksburg, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Pritts Timeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days disease or condition resulting in death) neumonia /Medical Due to (or as a consequence of): Examiner umatic mes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? henatoma 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed tractures Decondary to 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? 1 ☐ Yes 2 XNo alcident To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certifica 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2XNo-ျှ funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 X Accident 5 Pending 1/10/2014 1 ☐ Yes 2 No 17:01 Motorcycle Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Street Rt 32 @ Klee Mill Rd Finksburg, MP within 24 hours a To the Funerel D Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 0005,924 29d. Date signed (Month, Day, Year) D0062975 les la les WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Ave #307, Westminster, MD, 21157 299 Stones Weishaar 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 17 2005 Registrar

		,	For State Registrer	State of Maryla	-	artment o				giene	05 39	133	
	Physici	an	Decedent's Name (First, Middle, Last)	N					2. Date of Dea	ath Day	Yeer	me of Death	
	/Medic Examin	al	4a. Facility Name (If not institution, give st	reet and number)	121	4b. City. To	wn, or Location	on of Death	Novem	dc. County	2005 1	· 391M	
	Examin	er	Carroll Hospita	Center		Wes	tmins	ter			roll		
	Funeral		5. Social Security Number 6. Sex		rs. last birthday	If Under 1 Months D	Year If Und	ler 24 Hrs.	8. Date of Birt	h	9. Birthplace (S Country)	State or Foreign	
	Director		217-18-8857 1 <sup>4</sup>	231	82 Yrs.		<u> </u>		0ct.17	,1923	Marylan	d	
	yland yland		10a. State 10b. County	10c.	City, Town or L	ocation	·				10d. Ins	ide City Limits	
	e Mar	ctor	MD Carroll		Westmi	nster					1 [	XYes 2 □ No	
	vith th	Director	10e. Street and Number			10f. Zip Co				10g. Citizen of			
	eath v	eral	7 Marbeth Hill  11. Marital Status	2. Was Decedent Ever in	n II S 13		1157	Origin? (So	ecify Yes or No	U.S.A	• ce - American Indi	an	
စ္	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ent, the Medical Evantinet must be multified at	Funeral	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	10.	If Yes, specify	Cuban, Mexi	can, Puerto	Rican, etc.)	Bla	ck, White, etc.	αι,	
8	ural',	d by	3 Widowed 4 Divorced	Year or Dates:				uy.		Specif	white		
7	in 72 in 72	olete	15. Decedent's Education (Specify only highest grade	completed)	(Give	ident's Usual C is kind of work o DO NOT use i	done durina m	ost of work	ring	16b. Kind of B	usiness/Industry		
<u> </u>	d with	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			drive	r		fue	l oil co	•	
Maryland 21215-0036	be file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)				18. Mo	ther's Nam	e (First, Middle,	Maiden Sumai	ne)		
<u>   </u>	should be and Mental marked o	ို	E. Laverne Baust  19a. Informant's Name/Relationship (Typ.	- Orient	400 14			one C					
	and 2 si Balth an n 27 is r		Elsie L. Baust - v	-,,						MD 211	, State, Zîp Code) <b>57</b>		
ē,	s 1 ar if Hea item 3		20a. Method of Disposition	20	b. Place of Disp		of		Date		· City or Town, St	ate	
altimore,	Pages nent of I ant: If ite ury or o		1	moval from State		,	, ,	11/	16/2005	Uniont	own, MD		
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Iria Madical Examinist mast be nutified at ODGS.		21. Signature of Fyneral Service License	Xatler	/	2. Name and A				Funera or, MD			
	1		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that a sed the decause on each line.							Appro	ximate al Between	
	Physician		Immediate Cause (Final disease or condition	End stone	mixed	deme	untia				Onset	and Death	
	/Medical Examiner		resulting in death)	Due to (or a secon	No.	lv-		1 1	1	-41	- T		
	1 81	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury										
	cuted	Examiner	that initiated events										
Ö,	cate be executed physician and the burial-transit	I Ex	resulting in death) Last	Due to (or as a con-	sequence of):								
68760,	physic physic the b	dical	d.										
ŏ	death certific attending pl	n/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pre						23d. Da	te of delivery		
$\mathbf{\omega}$	that the death cer ed by the attendir detached for use	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown		□Ectopic pregr □ Other (speci				Мо	onth Day	Year	
P. O.	hat the d by the	Phy	9 ☐ Unknown  Part II. Other significant conditions cont		reculting in the	undach den en un	oo swaa is Da	m I	220 Did to	thacan use see	tribute to the caus	a of death?	
Vital Records,	ogu gu	Completed by Physician/Me	1		hronic	. A.	nmatio		1 🗆 1		./	4 Unknown	
000	aw requir s been si s should I	olete	Stage IV chronic	kidney d	isease				24a. Was		Were autopsy find	lings available	
E E	The la	mo.	Systemic inflammate		1	OWE			autop perfo	rmed?	prior to completio death? 1 ☐ Yes 2 ☐ No		
/Ita	cien: ertific	Be	25/Was case referred to medical	7	Syno	0110	1000	ace of Deat	h (Check only o				
of	Physicien: r this certific ral director,	٦.	1 Yes 2 No	28a. Date of Injury	2 ER/Outpatie			Nursing Ho		dence 6 Oth			
O	th. : After	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	r) Injury	M 280.	. Injury at Work? 1 ☐ Yes 2	□No	200. Describe i	low injury occur	190		
Division of	r Attandi er death rector: A by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, s	reet, factory, o	ffice		28f. Location (5 City or Tox		per or Rural Route	Number,	
	urs after oral Direction by		1	i						·			
	To the Hospitel or Attanding Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 VCertifying Physic (Check only one) 2 Medical Exemination	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, dea nination and/or i	th occurred at to restigation, in	the time, date my opinion, c	and place, death occur	and due to the ored at the time,	cause(s) and ma date and place,	anner as stated. and due to the ca	use(s)	
	To the Within To the	Me	29b. Signature and title of certifier	and the state of t			icense numbe			-	d (Month, Day, Ye		
)	111		> & Boston M	0		D	2846	2	] ]	Novem	ber 13,	2005	
	Wa		30. Name and address of person who cor	npleted cause of death (	11 11	1 0	1	3 I	1	Ave.	) 1		
	-0.		J Boston  31. Date filed (Month, Day, Year)	32. Registrar's Si	HOSPITI	al Cer	nter	We	stminste	er, Ma	ryland	21157	
	Sta Regist		NOV 1 6 2		w #	hours	,				f		

		•	For State Registrar		State	of Maryla	and / Depa <i>Cei</i>	artment of rtificate o			Mental H	ygiene Reg. No.		3913	L
	Physici	an	Decedent's Name			-					2. Date of D			3. Time of Dea	
	/Media	al	Delora			a contract		45 Oit T	1	(5.4	Novemb	18	2005	8:20 F	> м
	Examir	ier	4a. Facility Name (If I		unty Hos			4b. City, Town	, or Locati gerst		1	4c. County of Death  Washington County			J
	Funeral		5. Social Security Nu	mber 6	. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Day	r If Un	der 24 Hrs.	8. Date of B		9. Birth	place (State or For	
	Director		232-52-18		1□M 2X0F		75 Yrs.	Months Day	s Hou	IS MIII.		28 19		Virgini	ia_
	land ow		Usual Residence of D	10b. County		10c.	City, Town or Lo	cation						10d. Inside City Lir	mits
	Mary s-f sh	ţ	Maryland	Wash	ington		Hager	stown						1 ☐ Yes 💥	]No
	th tha	)irec	10e. Street and Numi					10f. Zip Code	)			10g. Citi	izen of What Cou	ntry?	
	death with the Maryland me 23s or 28s-f show rmust be notified at	rai		old Colo	ony Lane				1742				J.S.A.		
Maryland 21215-0036	ages 1 and 2 should be filad within 72 hours after death with the Marylan nt of Haelih and Mantal Hygians. If item 27 is marked other than "naturat", or iteme 23s or 28s-f show or other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marrie 3 🛣 Widowed 4	_	Armed	2 1X No		Was Decedent of Yes, specify Ci			pecify Yes or N o Rican, etc.)	lo-	14. Race - Ameri Black, White Specify: W		
2-0	72 h "natu	etec	(Specif	<ol><li>Decedent's fy only highest</li></ol>	Education grade completed	d)	(Give	dent's Usual Occ kind of work dor	e during n	nost of wor	king	16b. Ki	ind of Business/Ir	ndustry	
12	within ana. than	Completed	Elementary/Second	dary (0-12)	College	(1-4or 5+)		oo not use reri omemaker				Т	longonol	Residenc	70
9	filad Hygi other	Be C	17. Father's Name (F	First, Middle, La	ist)		110	MEMAREL		other's Nam	ne (First, Middl			Residenc	<i>.</i> e
ılan	uld be Aanta rkad tic ev	To B	Arthur	Delaude	er					Haze]	l Johns	on De	lauder		
lan	2 sho and l is me		19a. Informant's Nan		(Type, Print)			-				•	r Town, State, Zi	,	
	and faelth m 27		Ann Durs			001						-	Maryland		
altimore,	parmit. Pages 1 and 2 Department of Heelth a importent: if item 27 is any injury or other tra ance.		20a. Method of Dispo	Cremation 3		II State	cemetery, crer			i	Date		ecation - City or T		
ij	artman portant Injury	l	° 4 □ Donation 5			Pa	arsons I	Family C		-10th -	23–05			: Virgini	
Ba	parmi Dapa impo any ir		///	111210	1	1111				1				neral Hon	
	Prrysician /Medical		23a. Part1. Enter the shock, or heart Immediate Cause (F disease or condition resulting in death)	Final	a?	caused the deli each line.	eath. Do not ent	er the mode of d	ern r ying, such	as cardiac	or respiratory	ersto arrest,	own Mary	Approximate Interval Between Onset and Death	1
	Examiner				( )	1 Casa cons	d 2 (	Long	vui.	ture	$\Omega$	100	Salar		
	D =	ner	Sequentially list conditions, leading to mind cause. Enter Underly Cause (Disease or in that initiated events	ditions, nediate lving	D. Dust	o (or as a cons	equanca of).	EN:			1000		prant		
	cata ba axacutad physician and tha burial-transit	Examin	Cause (Disease or in that initiated events resulting in death) La	ńjurÿ ast	c.	- (		CLAZ	er						
8760,	ba ax ictan burial	aj E			Due (	o (or as a cons	equence or):								
687	ficata g physics the l	edicai			d										
P.O. Box	as that the death certifications to the death of the attending to be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 mm 1 □ Yes 2 □ 9 □ Unknown	nonths?	1.☐Live	outcome of preg birth 2 Fe gnant at time o	etal death 3	Ectopic pregnar Other (specify)	icy			2	23d. Date of deliv Month	ery Day Year	
	s that nad b	by Pi	Part II. Other signific	cant condition	s contributing to	death but not r	esulting in the u	nderlying cause o	jiven in Pa	art I.	23e. Did	tobacco u	se contribute to t	he cause of death	?
ords	wraquira bean sig should b	ted t	lu	ma a	2 N(2	<i>f</i>					TC.	Yes 2	□No 3□Prot	ably 4 Unkno	own
ecc	Tha law raquiras ta has bean sign aga 2 should ba	Completed		7				···			24a. Wa	s an opsy	24b. Were auto	psy findings availampletion of cause	able
<u>=</u>		Con									per 1 🗌 Yes	formed?	death? 1 ☐ Yes		
Vita	Phyaician: this cartific ral diractor,	Be	25. Was case referre examiner?		Hospital:				than		th (Check only				
ō	ding Phya I. Aftar this funaral di	-: To	1 ☐ Yes 2 ☐ N 27. Manner of Death	-	1	Hipatient 2 e of Injury	☐ ER/Outpatien 28b. Time of	t 3□ DOA 28c. In		Nursing Ho	ome 5 Res 28d. Describe		Other (Special	y)	_
On	nding th. : Afta s funa	tlon	1 ☑Natural 2 ☑ Accident	5 Pending investiga	(Mo	onth, Day Year)	Injury	W	ork? ⊒Yes 2	□No	200. 2000.120		, 00001100		
Division of Vital Records,	al or Attanding F s after death. il Director: After id in by the funari	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	be 28e. Pla	ce of Injury - Al Iding, etc. (Spe	t home, farm, str ocify)	eet, factory, office	9		28f. Location City or To	(Street and own, State)	d Number or Rura )	I Route Number,	
	To the Hoapital or Attanding Phyaician: within 24 hours after death. To tha Funeral Director: Aftar this cartific completaly filled in by the funeral director.	Medicai C	29a. Certifier 1 (Check only 2 one)	1 Certifying	aminer: On the	he best of my k basis of exami inner stated.	nowledge, death	occurred at the restigation, in my	time, date opinion, d	and place, death occur	and due to the red at the time	cause(s) , date and	and manner as s place, and due to	tated. the cause(s)	
	To t To t	Σ	29b. Signature and ti	itle of certifier	د ۱۱ ،	V ==	700	29c. Lice	nse numbe	, 2 <u>3</u>		29d. Date	e signed (Month,	Day, Year)	20
SH	- 7		30 Name and address	ss of person wi	o completed ca	/	ет 23а) (Туре,			.1.	( (		DAI	10000	
WH	Sta	te	31. Date filed (Month	Day, Year)	32.	Agistrar's Sig		01311	WE	alec	( or	Mul	120	ter Cities	NN
	Registr			VOV 23	2005	Policia		rede					mi	12174	2
DH CH	MH 17 Rev 1/2	001					7								

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] []

3	9	-	3	5

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edgar S. Burke November 12, 2005 1:50 P M /Medical 4a. Facifity Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Spring House Assisting Living Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Aug. 8, 7. Age (In yrs. last birthday). 89 Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral Ж**ПМ 2□ F 1916 Director 415-07-6442 Tennessee Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. fnside City Limits 28e-f show rel', or Itame 23a or 28e-f show Examiner must be notified at 1 XYes 2 No Directo Maryland Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2201 Colston Drive #610 20910 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. 1 XYes 2 No 1 Never Married 2 X Married naturel', or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1942-1945 1 ☐ Yes 2€ No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ than Elementary/Secondary (0-12) Administrator Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ralph G. Burke, Sr. Katie Mobley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: if item 27 is 2201 Colston Dr. #610, Silver Spring, MD (wife) 20910 Laura H. Burke 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐Cremation 3 ☐Removal from State Chesapeake Crematory 11/17/05 \* 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, MD 22. Name and Address of FacilityMcGuire Funeral Service 21. Signature of Funeral Service Licenses 'n nomo 7400 Georgia Ave. N.W., Wash. D.C. Part1. Enter the disease, or complications that tay sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate fnterval Between Onset and Death Immediate Cause (Final Physician Parkinson's Disease 4½ yrs. resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading to in reclair cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant at time of death ☐Yes 2☐No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 99 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Hypertension been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Colon Polyps has autopsy performed? Multi Nodular Goiter 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 \$\ Residence 6 Other (Specify) Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔼 No Certification: To this in by the funeral 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 5 Pending investigation 1 XNatural death. 1 Yes 2 No 2 Accident Director 6 ☐ Could not be 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 17 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1140 19th St. N.W. Ste. 500 Washington, D.C. Dale A. Matthews, M.D 31. Date filed (Month, Day, Year) 32 Aegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** WILLIAM BERNARD BARNES SR NOVEMBER DIYS 2005 5:26 Рм /Medical 4a. Facility Name (If not institution, give street and number)
FREDERICK MEORIAL HOSPITAL 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country). 5. Social Security Number **Funeral** 1/ M 2 F 260-28-1706 JAN. 11, 1925 Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Md. Frederick Frederick Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iteme 23a or Mc Murry 96 21701 V. S. A. death Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ØYes 2 □ No It#es, Give Year or Dates: 1950 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: BLACK þ 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Fred. County Sch. Bd College (1-4or 5+) 8 4 R S other then Elementary/Secondary (0-12) School Teacher/Bussinessman Sciff employed permit. Pages 1 and 2 should be filed v Depertment of Heelih and Menial Hygies Important: If item 27 is marked other th eny injury or other traumatic event, the once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barnes Crepla Morrison James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Frederick, Md 21701 Wite. 96 McMum Barnes yvonne 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rest Naven Mew. Cau. Nov 21, 2005 Frederick, Md. 21701 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenseen 22. Name and Address of Facility FUN GRAL HOME 21701 SOUTH ST 110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Theno SclenuTIL Cerebrovagular **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ettending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificete has autopsy performed? res 2 \(\sigma\) No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 Tyes 2 No within 24 hours after death. To the Funsrel Director: A 2 Accident the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Hospitel 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO035152 Mos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le + IVA 80 Thus Frederell MO Dr . 6 . 31. Date filed (Month, Day, Year) Registrar's Signature NOV 1 8 2005 Registrar

			1 - For State Registrar	State of Ma	aryland / I			of Health of Death		R	eg. No.	05 3	39137
	Physicia	an	Decedent's Name (First, Middle, Last	)					1	<ol><li>Date of Dea Month</li></ol>	th Day	Year	3. Time of Death
	/Medic	al	GEORGE	JAMES	CASI	EY				Nov.	24	2005	1710 P. M
	Examin	er	4a. Facility Name (If not institution, give			1		vn, or Location	of Death			ounty of Death	
	Comment		Laurelwood Care 5. Social Security Number 6. Se		e (In yrs. last bi	rthday)	If Under 1 Y	1kton Bar If Under	24 Hrs.   8	3. Date of Birth		cil 9 Birthr	place (State or Foreign
	Funeral Director			M 2□F 8		Yrs.		ays Hours	Min.	(Month, Day lay 31,	, Year)	Cour	ntry)
	ס		Usual Residence of Decedent						1 12	, 01,			sylvania
	arylar show	Ļ	10a. State 10b. County		10c. City, Tow		cation					1	10d. Inside City Limits
	8a-f	Director	Maryland   Cecil		E1kton		T						1 □ Yes 2 X No
	with t		10e. Street and Number				10f. Zip Cod					n of What Cour	•
	eath	eral	108 Stratton Ci	rcle 12. Was Decedent	Ever in II S	13 V	219	21 of Hispanic Or	igin? (Spec			d State	
(0	r Iten	Fun	1 Never Married 2 Married	Armed Forces?		Н	Yes, specify (	Cuban, Mexicai	n, Puerto Ri	ican, etc.)		Black, White,	
ဗ္ဗ	ral', o	by	3 X Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ N If <del>Y</del> es, Give Year or Dates:	1943− 1945	1	□Yes 2🏋	No Specify:			Sp	Decity: Whit	e
5-0	filed within 72 hours after death with the Maryland Hygiene. Ather than "natural", or Items 23a or 28a-f show ant, the Medical Examinat must be ricitlised at	Completed by Funeral	15. Decedent's Edu (Specify only highest grad		16a	(Give	lent's Usual Ockind of work do	one during mos	at of working	7	16b. Kind	of Business/In	dustry
7	vithin ne. han	mp	Elementary/Secondary (0-12)	College (1-4or 5			OO NOT use re	etired)				icipal	
7	illed v Hygie ther t nt, th		12 17. Father's Name (First, Middle, Last)	· · ·		ınsp	ector	18 Mothe	ar's Nama /	First, Middle,		Sing	
an	d be sontal	To Be	George J. Casey									,,,,,,,,	
Maryland 21215-0036	shoul nd Me mark	ř.	19a. Informant's Name/Relationship (T)	rpe, Print)	198	b. Mailin	g Address (Sti			McG1yı Route Numbei		own, State, Zip	Code)
Ž	nd 2 alth a 27 is r trat		Patricia Carlet	i/Daughte				n Circl				1921	·
Jre,	ges 1 and 2 should be filed within 72 hours after death with the Marylan in of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			of Dispos	sition (Name o	of	Decemb	te		tion - City or To	own, State
Ĕ	Page nent c		1 Donation 5 ☐ Other (Specify)	temoval from State		Sepu	1chre (	Cemetery	2005		Phila	delphia	a. PA
Baltimore,	permit. Pages 1 and Department of Health Important: If item 23 any injury or other t		21. Signature of Funeral Service Licens	99		Hi	Name and Ad	ddress of Facili	ty Funer	ale D	٨	21921	
_	205 g a		Donaid S	, Huch	رد	10	3 W. S	tockton	Št.,	Elktor	, MD	21921	
			23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	ications that caused ne cause on each lir	the death. Do	not ente	er the mode of	dying, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		neum		IA						Lwki
П	Examiner			Due to (or as	a consequence	of):							
		e	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):							
1	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uses or injury that initiated events	3.									
o,	a exec an an irial-tr	Exa	resulting in death) Last		a consequence	of):							
8760,	icate be executed physician and s the burial-transit	dicai		d									
ယ	death certifica attending pl	Med	IF FEMALE:	124 16	-4			-					
Вох	attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal death		Ectopic pregna				23d	<ol> <li>Date of delive Month</li> </ol>	Day Year
P.O.	that the death led by the atter detached for u	Physician/Me	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown	time of death	2	Other (specif)	//					
	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	by Ph	Part II. Other significant conditions co	ntributing to death b	ut not resulting i	in the un	iderlying cause	given in Part I		23e. Did tol	acco use	contribute to th	ne cause of death?
rds	w requires been sign should be	q pe	Certhro-	VASCULN.	Acc	ide	ent			1 □ Ye	s 2XII	No 3□Prob	ably 4 Unknown
Division of Vital Records,	faw requas been 2 should	Completed	AWIAL	FWILLAR	0~					24a. Was a		4b. Were auto	psy findings available
ž	The favate has	mo;	Hyperte	noion						autops perform	med? 2 X No	death?	inpletion of cause of 2□ No
ita/	ctor.	Be (	25. Was case referred to medical examiner?					26. Place	of Death (	Check only on			
<u>&gt;</u>	hysic this co	2	1 ☐ Yes 2 XNo	lospital: 1 ☐ Inpatie		-						Other (Specify	y)
й	fing F	lon:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injui (Month, Day	Year) 28b.	Time of Injury		Injury at Work? 1 ☐ Yes 2 ☐		d. Describe ho	w injury o	ccurred	
S	otendi death. ctor: A y the fu	licat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	ırv - At home fa	arm stre				f. Location (St	met and N	iumher or Rum	l Route Number,
<u>S</u>	after after Direct	Certification:	4 Homicide determined	28e. Place of Injubulding, etc	. (Specify)	,	, idolory, on			City or Town	, State)		, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge	e, death	occurred at th	ne time, date an	id place, an	d due to the ca	ause(s) an	d manner as st	ated.
	he Ht in 24 he Fu pletel	Medical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	examination ar ited.	nd/or inv	estigation, in r	ny opinion, dea	th occurred	at the time, d	ate and pla	ace, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	/	1		29c. Lic	cense number		2		igned (Month, I	
	۱)		P; H Non	ell s	1)		D	3351	0		11-2	25-2	005
•	ibx,	(8	1/ 0.1	empleted cause of d	eath (Item 23a)	(Туре, і	Print) 7 2	Par	Ja D	12A	1/2	. k A	= 19702
	10		31. Date filed (Month, Day, Year)	100041	M - D ar's Signature	UU	16 24	120)	is 11	AtA ,	New	NK, UC	19404
	Sta Registr		No. only a	2005	· A	-	beet s						

Amend#'s 8.11.17.0	& 18. Per Infint.PCC 11—21-State of Maryland / Depa 1- State Registrar Amend#29d.Per Phys.PGC11—18-09	artment of Health and M ctificate of Death	lental Hygiene	005 39138
Physician	1. Decedent's Name <i>(First, Middle, Last)</i> Barbara A. Carter		2. Date of Death Month November 10,	3. Time of Death 2005 11:00a M
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 11412 Old Prospect Road	4b. City, Town, or Location of Death Glen Dale		ounty of Death  Ince Georges
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 223-54-1875 1□ M 2⊠ F 64 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth 48. (Month, Day, Year) Apr 18, 1941	
re, Maryland 21215-0036 s t and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglane. Item 27 is marked other than "naturel", or Iteme 23e or 28e-f show other treumatic event, the Madical Exeminer must be notified at To Be Completed by Funeral Director	Amed Forces?  1	10f. Zip Code 20769  Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☑ No Specify:  dent's Usual Occupation kind of work done during most of work DO NOT use retired)  1ffice Manager	Unit  actify Yes or No- Rican, etc.)  16b. Kind  Priv  a (First, Middle, Maiden, Si  bbard Mary F  al Route Number, City or 7	10d. Inside City Limits 1 [X] Yes 2 □ No n of What Country? ted States Race - American Indian, Black, White, etc. pecify: Black of Business/Industry ate Industry finame) 3. Green From State, Zip Code)
Baltimore, N permit. Pages t and Department of Health important: if item 27 eny injury or other tr	20a. Method of Disposition  1		20c. Loca 5/05 Alexa	tion - City or Town, State
ficate be executed  Indicate be executed  In	23a. P. 1. Enter the dis ase, or complications that caused the death. Do not enishock, or heart failure. List only one cause an each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	er the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onserand Death
P.O. Box 6 at the death certifi by the attending tached for use es tached for Jack		Ectopic pregnancy Other (specify)	236	d. Date of delivery Month Day Year
	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	1 □ Yes 2 💢	
f Vital Record ysician: The law requi iis certificate hes been s director, page 2 should To Be Completed	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 FeVOutpatien	Other	24a. Was an autopsy performed?  1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
ding Atter	27. Manner of Death  1 XNatural 5 Pending 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)  28a. Date of Injury (Month, Day Year)  28b. Time of Injury - At home, farm, structure building, etc. (Specify)	f 28c. Injury at Work? M 1 □ Yes 2 □ No	28d. Describe how injury o	
Hospita 4 hours Funerei ely filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deat 2 Medical Examiner: On the basis of examination and/or in an manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occuri	and due to the cause(s) ared at the time, date and pl	nd manner as stated. ace, and due to the cause(s)
To the within 2 To the complet	29b. Signature and title of certifier	29c. License number 0 0 0 3 752	29d. Date 9	signed (Month, Day, Year)
State	30. Name and address of cerson who completed cause of death (Item 23a) (Type,	mercaptile L	cre La	50 m020776
Registrar	NOV 1 8 2005 Beach & Speed	E.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 7, **Physician** Larry L. Campbell 2005 11:43 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Springs Montgomery 8. Date of Birth (Month, Day, Ye Dec. 8, 1 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 ★M 2 F 216-02-3723 Director 32 1972 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 XYes 2 ☐ No Director MD Prince George's Hyattsville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6117 Sargent Road 20782 USA death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ZENo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filled within 72 hours atter of and Mental Hygiene. Is marked other than "natural", or Itel 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: À 3 Widowed 4 Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor 12th Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jampsey Campbell Shirley Taylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sr Department of Health and Importent: If Item 27 is n any injury or other traun once. Shirley Pender/Mother 6117 Sargent Road Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln CemeteryNov.14,2005 ^4 □ Donation 5 □ Other (Specify) Brentwood, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of FacilityJohnson and Jenkins Funeral Home 716 Kennedy Street NW Washington, DC 20011 23a. Part. Enter the disease, or complications but caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician CARDIAC ARRHYTHMIA resulting in death) /Medical Due to (or as a consequence of): Examiner DILATED CARDIOMYOPATHY Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury as a consultuence of requires that the death certiticate be executed attending physician and tor use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the at the detached to 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy performed? 2 🗆 No 1 XYes 2 No Yes Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 X Inpatient 2 ER/Outpatient Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) November 8, 2005 D40611 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10313 Georgia Ave. #306 Silver Springs, MD 20902 Alan Schneider, MD 31. Date filed (Month, Day, Year) State Registrar

University   Uni	39140
The County Vame (if not estantiate, you wind and number)  Laurel Regional Hospital  Socs South Number  250—20—967   6. Size  250—20—967   1. Size  South Number  250—20—967   1. Size  South Number  250—20—967   1. Size  South Number  250—20—967   1. Size  South Number  250—20—967   1. Size  South Number  250—20—967   1. Size  South Number  250—20—967   1. Size  South Number  250—20—967   1. Size  South Number  120—20—10—10—10—10—10—10—10—10—10—10—10—10—10	3. Time of Death
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The First Name (First, Middle, Last)  James E. Craig  Annise Brownlee  Annise  Annise Brownlee  Annis	10d. Inside City Limits 1 ŽYes 2 ☐ No
The First Name (First, Middle, Last)  James E. Craig  Annise Brownlee  Annise  Annise Brownlee  Annis	•
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Second   Continue	Industry
20. Method of Disposition   Special Section   Sp	e
Register   Community   Commu	· · · -
Physician Medical Examiner  23a Part, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician Medical Examiner  Physician Medical Examiner  Physician Medical Examiner  Secuentially list conditions, flary, legicing to immediate disease or coordino receiling in seath). Secuentially list conditions, flary, legicing to immediate disease or coordino receiling in seath). Secuentially list conditions, flary, legicing to immediate disease or coordino receiling in seath). List is resulting in death).  resulting in death is resulting in the underlying cause given in Part I.  Cirrhosis of Liver  Atrial Fibrillation  23a. Date of death with resulting in the underlying cause given in Part I.  Lives 2 No. 3 Reproduced the resulting in the underlying cause given in Part I.  Lives 2 No. 3 Reproduced the resulting in the underlying cause given in Part I.  Lives 2 No. 3 Reproduced the resulti	
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FFEMALE   23d. Date of deliver   23d. Date	
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25. Was case referred to medical examiner?  1	topsy findings available ompletion of cause of
The patient of Description of Descri	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	ify)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	stated. to the cause(s)
30. Name and address or person who completed cause of death (item 23a) (Type, Print)	
TELL TO THE PROPERTY OF THE PR	17,05
State 31. Date filed (Month, Day, Year) Registrar  NOV 2 1 2005	

			1 - For State Registrar	State	of Maryla		artment of H rtificate of I		and Me		ene () ()	15	39141		
	Physicia		1. Decedent's Name (First, Middle, Pearl Louise	_						2. Date of Death Month November	Day	Year	3. Time of Death 12:30рм		
	/Medic Examin		4a. Facility Name (If not institution,		u <i>mber)</i>		4b. City, Town, or	Location of		NOVEILDEL	4c. County				
		•	Avalon Manor	Nursing			Hagers	town			Wasi	hingt	on		
	Funeral Director		5. Social Security Number 214-16-0224	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs	s. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Dec. 17,	Year) 1920	Cou	place (State or Foreign ntry) vland		
	pu »		Usual Residence of Decedent		100.0	City, Town or Lo									
	shoy	7	10a. State 10b. County										10d. Inside City Limits 1    1    Yes 2   No		
	the N	Director	Maryland Washin  10e. Street and Number	igton	<u> </u>	lagerst	OWN 10f. Zip Code			10	g. Citizen of \	What Cou	ntry?		
	atter death with the Maryland or Items 23a or 28a-f show onner must be notified at		1127 Outer Dri	Ve			21740				USA				
	death	Funeral	11. Marital Status		cedent Ever in	U.S. 13.	Was Decedent of H		gin? (Spec	ify Yes or No-	14. Rac		can Indian,		
36	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural; or flems 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 Never Married 2 Married 3 StWidowed 4 Divorced		2. 2. No Sive		1 ☐ Yes 2X No	Specify:	, , , , , , , , , , , , , , , , , , , ,	nouri, etc.,		ck, White, y: Whi			
9500-61212	72 hou	Completed	15. Decedent (Specify only highes		4)		dent's Usual Occup		of working	1	6b. Kind of B	usiness/In	dustry		
7	filed within 72 Hygiene. hther than "nat ent, the wedict	nple	Elementary/Secondary (0-12)	1	(1-4or 5+)	life.	DO NOT use retired	1)	Or WORKING	9	-				
	filed w Hygier other th	S	10 17. Father's Name (First, Middle, I	acti		Own	er/Operat		r'e Nama	(First, Middle, M	Beau				
Maryland	d be f	o Be	Jess Martin	.431/					nny K		alden Suman	10)			
<u></u>	es 1 and 2 should be of Health and Mental if item 27 la marked or other traumatic ever	2	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailir	ng Address (Street				City or Town,	State, Zij	Code)		
	and 2 ealth a n 27 la		William L. Cook	II/Son		15610	Deer Lo	dge C	irc1e	, Hager	stown,	Md.	21740		
or e	of He fiter		20a. Method of Disposition 1₺ Burial 2 ☐ Cremation	3 □Removal from	20b.	Place of Dispo cemetery, cres	sition (Name of matory or other place	:0)	Da	ite 2	0c. Location -	City or To	own, State		
Ĕ	. Pages tment of tant: If it jury or o		` 4 □Donation 5 □ Other (Sp	ecify)	Re								Maryland		
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service I	icensee			2. Name and Address 801 Penns						•		
			23a. Part1. Enter the disease, or	complications that	t caused the de							, 11d	Approximate Interval Between		
	Physician	K (	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition a.												
	/Medical Examiner		resulting in death)			(20)									
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	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause (Disease or injury	546 (	o (oi as a conse	equence on.									
C.	execu an and rial-tra	Examin	that initiated events resulting in death) Last	c	o (or as a conse	equence of):									
8760	icate be executed physician and s the burial-transit	dical		gr			·· · · · · · · · · · · · · · · · · · ·		<del> </del>						
ဖ		/Mec	IF FEMALE:	23c If yes o	outcome of preg	ID 300V									
Вох	death certifii e attending p id for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 Fe gnant at time of	etal death 3	Ectopic pregnancy Other (specify)					te of deliventh	ery Day Year		
o.	the d y the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk											
S,	signed by det	by P	Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	nderlying cause giv	en in Part I.					he cause of death?		
g	w require been si should?		Renel Cal	aly	with	Myd	a replace	nis		1 🗆 Yes	2 □ No	3 🗌 Prot	pably 4 Hunknown		
Records,	as as as	Completed	Morelun	in 0	emen	Tien				24a. Was an autopsy perform	·	Were auto prior to co death?	ppsy findings available impletion of cause of		
	10 14		OS Man area referred to modical							1 ☐ Yes 2	□ NO	1 🗆 Yes	2 No		
Vital	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	☐Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	00		(Check only one e 5 ☐ Resider		er (Specia	(v)		
٥	ding Physician: h. After this certific funeral director,	ı	27. Manner of Death	28a. Dat	te of Injury onth, Day Year)	28b. Time o		y at		3d. Describe how			,,		
<u>S</u>	Attending r death. ector: After y the fune	atlo	1 Accident 5 Pending	ation		,,		Yes 2□N	No						
Division		Certification:	3 Suicide 6 Could r 4 Homicide determ	200. Fla	ce of Injury - At Iding, etc. (Spec	.home, farm, str cify)	reet, factory, office		28	8f. Location (Stre City or Town,		er or Rur	al Route Number,		
_	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 Gertifyin	g Physician: To t	he best of my k	nowledge, deat	h occurred at the tin	ne, date and	d place, ar	nd due to the car	use(s) and ma	anner as s	tated.		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	ledical	one)	and ma	basis of exami anner stated.	nation and/or in	vestigation, in my o		in occurred						
ı	With To	Σ	29b. Signature and title of certifier	12.00	~0		29c. Licens			1	d. Date signe o		Day, Year)		
				-								- /			
4	1-0		30. Name and address of person	who completed ca	iuse of death (It	1em 23a) (Type.		L 5-	7	MAGER	25700	Va	2021740		
	Sta	ite	31. Date filed (Month. Day, Year)	32.	. Registrar's Sig	nature									
	Regist	rar	NUV 2	2 2005	Derew	B. 1	pole								

				tem 25 per	larylan <b>verb</b> .	d / Depa	artmer	1 05 H	ealth a dhb Death	ind M			005	39	142
A.	Physici	an	Decedent's Name (First, Middle,	. Last)							2. Date of De Month	Da			e of Death
	/Medic		Doris	Anita	,		Cla				novembe		25 200	2 100	29 AM
	Examin	er	4a. Facility Name (If not institution,				1		Location of	f Death			. County of De		
			Washington Coun  5. Social Security Number			last birthday)		ersto	own If Under 2	24 Hrs.	8. Date of Bi	$\overline{}$	Vashing		te or Foreign
L	Funeral Director		215-14-2637 Usual Residence of Decedent	1 □ M 2 🂢 F	86	Yrs.	Months		Hours	Min.	(Month, Di	ay, Year	1919 Ma	ountry)	
	yiand 10W		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside	e City Limits
	Mar.	tor	MD Washin	gton	Hag	gerstow	m							101	′es 2√ No
	ith the	Oire	10e. Street and Number					p Code				10g. C	tizen of What C	ountry?	
	ath w	rai	9721 Meadow Roo				217						U.S.A.		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f ehow appring or other traumatic event. The Medical Examinal trausities notified at ance.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Marrie  3 ☒ Widowed 4 □ Divorced	12. Was Deceden Armed Forces at I Yes 2 X If Yes, Give Year or Dates	? ] No		Was Dece If Yes, spe 1 \( \text{Yes}		ispanic Orig n, Mexican Specify:	gin? (Spe , Puerto F	cify Yes or No Rican, etc.)	0-	14. Race - Am Black, Wh Specify: Wh	ite, etc.	1.
2	72 hc	Completed	15. Decedent' (Specify only highest			16a. Dece	kind of wi	ork done d	turina most	of workir	na	16b. k	Kind of Busines	s/Industry	
2	han *	μpi	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT I	ise retired	)		·9		<i>-</i>		
'n	tygie tygie ther t		17. Father's Name (First, Middle, L	1		Secre	tary		10 Matha	da Nama	(First, Middle		ufactur	ing	
Maryland 21215-0036	Mental Harked of	To Be	George F. Weag			_					Miller	, маюв	n Sumame)		
Mar	alth and 27 is m		19a. Informant's Name/Relationsh Deborah Ann Corr		er						Route Numb		or Town, State.  MD 217		
Baltimore,	of He		20a. Method of Disposition 1 → Burial 2 □ Cremation	2 Dameual from State	20b. F	Place of Dispo cemetery, crei	osition (Na matory or	me of other plac	e)	D	ate	20c. L	ocation - City o	r Town, State	)
Ĕ	Pag ment ant: I		4 □ Donation 5 □ Other (Sp		Res	t Have	n Cer	neter	у 1	1/29	/2005	Hag	erstown	, MD	
a	permit. Departimporti		21. Signature of Funeral Service L	icensee		22	2. Name a	nd Addres	s of Facility	Res	t Have	n Fu	meral (	hape1	
	20239		. S. Mark	Sugn		1	601 1	enns	ylvan	ia A	ve., H	ager	stown,		1742
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	complicated state cause only one can be considered as a second se			-		g, such as o		r respiratory a	rrest,			mate Between nd Death
8760,	cate be executed physiclen and the burial-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a		Laulu Vence of):	ne	,						toda	ays.
P.O. Box 6	The law requires that the death certificate be executed as been signed by the attending physiclen and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Feta	Ideath 3	⊒Ectopic p □ Other (s						23d. Date of de Month	elivery Day	Year
	w requires that been signed b should be deta	þ	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	inderlying	cause give	en in Part I.			tobacco Yes 2	use contribute t		of death?
Division of Vital Records,	: The law required has been page 2 should	Completed									24a. Was auto perfe 1 Tes		prior to death?	utopsy findin completion o	gs available of cause of
<u> </u>	certifi ector	Be	25. Was case referred to medical examiner?	Hospital:				Otho			Check only				
ŏ	Attending Physician: r death. ector: After this certifice by the funeral director, p	7: To	1 ☐ Yes 2 ▼ No 27. Manner of Death	Hospital: 1 Inpai		ER/Outpatier 28b. Time o			4 🗆 1401		ne 5 ☐ Resi 8d. Describe		6 □Other (Spe	ecify)	
on	ding th: Afte	tor	1 Natural 5 ☐ Pending 2 ☐ Accident investig	(Month, D	ay Year)	Injury	м	28c. Injury Work	c? Yes 2 □ N				.,		
Divisi	I or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of I	njury - At he etc. <i>(Specif</i>	ome, farm, str	reet, factor	y, office		2	8f. Location ( City or To		nd Number or F e)	lural Route N	lumber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai C	29a. Certifier 1 Certifying (Creacy Conty one)	g Physician: To the bes xanimer. On the basis and manner	or examina	owledge, deat ition and/or in	h occurred	l at the tim	ne, date and pinion, deat	d place, a	nd due to the	cause(s	) and manner a d place, and du	s stated. e to the caus	ee(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner t			29	c. License	number			29d. Da	ite signed (Mon	th, Dav. Yea	r)
)	P S ⊢ Ö		Marion	9 Ahas	$\overline{}$			now	26-				1 25	, <del>-</del>	
	6		30. Name and address apperson of	who completed cause o	death (Iter	n 23a) (Type,		ch.	A	No	0.1		1910	21-	140
	Sta	to	31. Date filed (Month, Day, Yeak)	32. Fledis	trar's Sign	Mure	u,	s i le	w	146	Leson	w	_ • • • • •		
	Regist		DEC 0 5 2005	frank 1	1	sele									

			State of Mar State Registrar		artment of Health and rtificate of Death		ene g. N2 0 0 5	39143
	Physici		1. Decedent's Name (First, Middle, Last) Annette	Cay	vard	2. Date of Death Month November		3. Time of Death 12:15P.M
	/Medic Examir		4a. Facility Name (If not institution, give street and number) Frederick Memorial Hospital		4b. City, Town, or Location of Do Frederick		4c. County of Deal	k
	Funeral Director		5. Social Security Number  113-36-1822  G. Sex  1 □ M 2 ▼ F 7. Age (1)  Usual Residence of Decedent	(In yrs. last birthday) 78 Yrs.	If Under 1 Year   If Under 24 Hours   N	lin.  8. Date of Birth (Month, Day, Jan.16,1	Year) 9. Birt Ço 1927 Hai	hplace (State or Foreign buntry) ti,WestIndie:
	Maryland a-f ehow	tor		Oc. City, Town or Lo Beltsvil				10d. Inside City Limits 1 ☐ Yes 2∑ No
	h with the 3a or 28 st be not	al Director	10e. Street and Number 3310 Fullerton Street		10f. Zip Code 20705		og. Citizen of What Co Jnited Sta	
980	72 hours after death with the Maryland natural; or Items 23a or 28a-f ehow dical Exacuter must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Evarried Forces? 1 Yes 2 No		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 ☐ Yes 2 ☑No Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame Black, Whit Specify: B	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items any injury or other traumatic event, It a Medical Examine fine.	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (9-12)  College (1-4or 5+	(Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working 1	self emplo	
	uld be file fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Emeril C	ayard		Name <i>(First, Middle, M</i> th Charle		
Maryland	and 2 shousalth and No. 27 Is mail		19a. Informant's Name/Relationship (Type, Print) Dorthy M. Cayard -niece		ng Address <i>(Street and Number of</i> Fullerton Stree			
Baltimore,	Pages 1 a nent of Hea int: If item		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5  Other (Specify)		osition (Name of matory or other place)		oc. Location - City or aurel, Mai	
Balti	permit Departn Importa any inju		21. Signature of Funeral Service Licensee	136 44	bhaid Vor Bofgwar 400 Powder Mill	dt Funeral Road Belts	Home, PA	cyland 20705
	Pnysician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death)	ne death. Do not ent	er the mode of dying, such as care			Approximate Interval Between Onset and Death
8760,	death certificate be executed  e attending physician and dcr use as the burlat-transit	dical Examiner	Sequentially list conditions, any latting immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):	ENTIA			years.
O. Box 6	death certifi e attending I id for use as	Completed by Physiclan/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of del Month	ivery Day Year
α.	w requires that the been signed by th should be detache	ed by Pl	Part II. Other significant conditions contributing to death but  Atypical Psychology.	not resulting in the u	nderlying cause given in Part I.		acco use contribute to s 2□No 3₽Pr	the cause of death?
of Vital Records,	The law ate has b page 2 s					24a. Was an autopsy perform 1 Yes 2	24b. Were au prior to death?	topsy findings available completion of cause of
Division of Vita	ng Phys fter this neral di	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2  No	28b. Time o Injury	Other: 4 Nursing 128c. Injury at Work?  M 1 Yes 2 No	g Home 5 Resider  28d. Describe how  28f. Location (Str.  City or Town,	nce 6 □Other (Spec w injury occurred eet and Number or Ru	
D	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Cer	29a. Certifier 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e	xamination and/or in	h occurred at the time, date and pl vestigation, in my opinion, death o	ace, and due to the car	use(s) and manner as te and place, and due	stated. to the cause(s)
	To the within 2 To the complete	Med	29b. Signature and title of certifier		29c. License number	N	d. Date signed (Monti	
>	2-972-12-0	-3	30. Name and address of person and completed cause of dea 8850, CELURBIN 100 Panks	lay, # 3	es columbia	a , MD-	21045.	
:	St Regist	ate rar	31. Date filed (Month, Day, Year)  NOV 1 7 2005  32. Registrar	s Signature	Coorles			

			For State Registrar	State of M		artment of F <i>rtificate of</i>	lealth and Mental I <i>Death</i>	Hygien Reg. N	UUU.	39144
	Physici /Medic		1. Decedent's Name (First, Mic John Henr		Jr.		2. Date o		Day 15 Year	3. Time of Death
	Examin		4a. Facility Name (If not institut Manckin	ion, give street and number)		4b City, Town, o	r Location of Death SS Anne	4	So m	erset
	Funeral Director		5. Social Security Number 220 – 26 – 7739	6. Sex 7. Aq ★ M 2 F	ge (In yrs. last birthday) 76 Yrs.	Months Days	Hours Min. 8. Date o (Month	Birth , <i>Day</i> , Yea 11,1	9. Birth Con	nplace (State or Foreign untry)  Md.
	and aw	}	Usual Residence of Decedent  10a. State 10b. Coun	ity	10c. City, Town or L	ocation				10d. Inside City Limits
	Maryl -f sho	tor	Md. Some	erset		ss Anne				1X Yes 2 No
	h the	Funeral Director	10e. Street and Number			10f. Zip Code		10g. C	Citizen of What Cou	untry?
	23a c	aiD	12409 Lore	etta rd.		218	53		USA	
	er dea	une	11. Marital Status	12. Was Decedent Armed Forces	?	Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Specify Yes o an, Mexican, Puerto Rican, etc.	No-	14. Race - Amer Black, White	rican Indian, o, etc.
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinat must be notified at	by F	1 X Never Married 2 M 3 Widowed 4 Divorc	If Yes Give 1	No	1□ Yes 2□XNo	Specify:		Specify: Bl	ack
21215-0036	2 hou	ted	15. Deced	ent's Education	16a. Dece	dent's Usual Occup	ation	16b.	Kind of Business/I	
215	ithin 7 ie. ien "n	Completed	Elementary/Secondary (0-12	hest grade completed) 2) College (1-4or	5+) /ife.	DO NOT use retired	during most of working d)			
	filed wi Hygien other th	Con	09		Bus	Driver			oultry	
Maryland	2 should be filed within and Mental Hygiene. is marked other than aumatic event, ILA ME	Be c	17. Father's Name (First, Middle)	ry Cottman,	Cr		18. Mother's Name (First, Mic			
Z	should nd Me mark imarid	<u>L</u>	19a. Informant's Name/Relatio			ing Address (Street	Betty Wa and Number or Rural Route No	ters Imber. City		in Code)
	alth ar 27 is 27 is		Lovan M.	Smith/ Sis			Island rd.			
ore,	es 1 a of He of He r item r othe		20a. Method of Disposition	n 2 Damoual from State	20b. Place of Disp	osition (Name of	Date	20c.	Location - City or 1	
Ĕ	Pag ment ant: i			n 3 □Removal from State (Specify)			ory 11/20/05		ver, De.	
Baltimore,	permit. Pages 1 and 2. Department of Health a Important: if item 27 is any injury or other trau once.		21. Signatur of Euneral Servi	ce Licentee	9	2. Name and Addre	ss of Facility Bennie Sabella, St.	Smi Sali	th Fune sbury,M	ral Home d.21801
п			23a. Part1. Enter the disease, shock, or heart failure. L	or complications that cause ist only one cause on each l	d the death. Do not en line.	ter the mode of dyir	ng, such as cardiac or respirato	ry arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	ASCVI	)				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	s a consequence of):	-				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1						
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68760,	tificate be executed ig physicien and as the burial-transit	edical		d						
	n certific anding p use as		IF FEMALE:	23c. If yes, outcome	of orognapay					
Box	atte	by Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of deli-	very Day Year
0	the y th	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown						
S, P	requires that een signed b nould be deta	by P	Part II. Other significant cond	itions contributing to death	but not resulting in the u	underlying cause giv	en in Part I. 23e. I	oid tobacco	use contribute to	the cause of death?
ord	w require been slo should b	ted t						☐ Yes	2□No 3□Pro	bably 4 Unknown
Records,	aw 2 st	Completed					a	Vas an utopsy	prior to o	opsy findings available ompletion of cause of
E H	Thate page						1 \ Y	erformed? s 2 1	death?	
Vital	Physician: Th this certificate al director, pag	Be	25. Was case referred to medi examiner?	Hospital:		Oth	26. Place of Death (Check of			
of		To It	1 ☐ Yes 2 ☑ No 27. Many er of Death	28a. Date of Inj	ury 28b. Time o	nt 3LI DOA	4 Nursing Home 5 1		6 □Other (Speciary occurred	ify)
Division	Attending I r death. actor: After by the funer	Certification:	1 ☑ Natural 5 ☐ Pen 2 ☐ Accident inve	ding (Month, Da stigation	ay Year) Injury		k? Yes 2 □No			
<u>×</u>	r Atte er dea recto	tific		ald not be 28e. Place of In building, e	jury - At home, farm, st	reet, factory, office		n (Street a	and Number or Rui	ral Route Number,
Q	iltal o urs aft rai Di									
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director:	edical	29a. Certifier 1 Certification (Check only one)	rying Physician: To the best cal Examiner: On the basis of and manner s	of examination and/or in	th occurred at the tir rvestigation, in my o	ne, date and place, and due to pinion, death occurred at the ti	the cause( ne, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of cert	N/W		29c. Licens			ate signed (Month	_
							094		11/15705	
			30. Name and address of pers	1415	5. DIVISION		Strishvoy	ms.	21804	
	Sta Regist		31. Date filed (Month, Day, Ye	7 2005 32. Regist	trar's Signature	sall !				

State of Maryland / Department of Health and Mental Hygiene, 39145 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dev **Physician** Katharine E. Clarke 22 Nov 2005 7 AM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 331 Red Clard Road Lusby Calvert 8. Date of Birth (Month, Day, Year) June 17 1906 If Under 1 Year If Under 24 Hrs 5. Social Security Number 7. Age (In vrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 □ F 99 250-12-3580 Director New York Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiena. Important: If Item 27 is marked other than "natural; or items 23e or 28e-f show 10a. Stete 10b County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at Maryland Calvert Lusby 1 ☐ Yes 2√2 No **Funeral Director** 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 331 Red Claud Road 20657 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Completed by Specify: white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 havenaker own hame 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William J. Platte Catherine Hiccins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Caroline C. Clarke-daughter 331 Red Cloud Rd. IUSby Maryland 20657 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Nov 28 2005 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ö Yachank Cenetery eny injury Long Island New York 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Rausch Funeral Hone 4405 Broomes Island Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Be Completed by Physician/Medical Examiner ed by the attanding physician and datached for usa as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 12 Yes 2 No 3 Probably 4 Unknown To the Funeral Director: After this certificate has been signed complataly filled in by the funeral director, page 2 should be dai ester heart failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yus 2 UNO Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 Yes 2 No edical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1- Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō within 24 hours a To the Funerel [ 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Yeer) 105 of person why completed cause of deeth (Item 23e) (Type, Print) Sylvia Batong H.G. Truemen Rd. LUSby Maryland 20657 31. Date filed (Month, Day, Year) 32. Registros Signature State NOV 2005▶ Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5, perFH, C850, 12/5/05 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) David Benjamin Dent 13, 1:51 AM M November 2005 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Community Hospital Cheverly Prince George's 8. Date of Birth (Month, Day, Year)
June 27, 1 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. \$40°4516 41-4516 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F 73 1932 North Carolina Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Prince George's Capital Heights 1¥ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 802 Carrington Ave. 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 1₹ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: **Black** 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry United States Soldier's Elementary/Secondary (0-12) College (1-4or 5+) and Airmen Home 12th **Head Nurse** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) David Benjamin Dent Sr. Sula Mangrum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dana Dent / Daughter 802 Carrington Ave. Capital Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Fort Lincoln CemeteryNov.21,2005 Brentwood, MD <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Johnson and Jenkins Funeral Home 21. Signature of Funeral Service License 716 Kennedy Street NW Washington, DC 20011 23a. Parf1. Enter the disease, or compilations that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arri Immediate Cause (Final disease or condition resulting in death) Due to (or as a conseque Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 0 No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760. P.0. Division of Vital Records.

**Physician** 

/Medical

**Examiner** 

Directo

Funeral

ģ

Completed

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any Injury or othar traumatic event. The Madical Examiner: Just be notified at once.

Physician /Medical

**Examiner** 

burial-transit

the phys as use

be detached for

page

by Physician/Medical Examiner

Be Completed

Certification: To

Medicai

3 🗌 Suicide

(Check only one)

29b. Signature and title of certification

29a. Certifier

Baltimore, Maryland 21215-0036

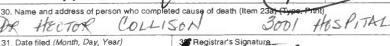
within 24 hours after death To the Funeral Director: /

State Registrar

31. Date filed (Month, Day, Year)

NOV 1 8 2005

6 Could not be determined



and manner stated.

Registrar's Signature.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🔏 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State of Maryland / Department of Health and Mental Hygiene 0 0 5 For State Registrat Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year November 15, 2005 **Physician** 5:30 William Peter Dorr АМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 2605 Kenhill Drive Bowie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/13/1923 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1⊠M 2□F 577-24-2357 Washington, Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Item 27 is marked other then "naturel", or Items 23s or 28s-1 show other treumstic svent, the Madical Examinar must be notified at 1X Yes 2 □ No Directo Maryland Prince Georges Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2605 Kenhill Drive 20715 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 2 should be filed within 72 hours after in and Mental Hygiene. Is marked other then "naturel", or Itel Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 143-146 1 ☐ Yes 2 X No Specify: à Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Heating & Air 10 Master Electrician Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lawrence Peter Dorr Catherine Margaret Perry 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m any Injury or other treum 2005. 2605 Kenhill Drive Bowie, MD 20715 Ethel May Dorr/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 11/19/2005 Brentwood, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the pide of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Dirator Physician disease or condition resulting in death) /Medical Due to (or as a onsequence of Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Lance 25 Examiner physicien and s the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as guipo IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery signed by the etter I be detached for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 27 No 1 ☐ Yes Division of Vital or Attending Physicien: effer death. Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 Z No 1 Inpatient 2 ER/Outpatient 2 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide To the Hospitel or Attention 24 hours efter de To the Funerel Direct completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature le of certifier Dirensel 30. Name and address of fer on who completed se of death (Item 23a) (Type, Print) 7525 Greenway C.F. Drive gistrar's Signature 31. Date filed (Month, Day, Year 32. State 2005 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Ma	•		rtment tificate			ınd M		giene Reg. No.	2005	39148
ı	Physicia		1. Decedent's Name (First, Middle, Las								2. Date of Dea	er I	5,20 <sup>y</sup> 85	3. Time of Death 9:40AMM
	/Medic Examin		4a. Facility Name (If not institution, give 20713 Aquasco H	street and number)				Fown, or	Location o			4c. (	County of Deat	
Ī	Funeral Director			ox 7. Age ČM 2□F	(In yrs. last birt	hday) Yrs.	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, Da Mar . 1	р У <sup>У е а г</sup> )	9. Birtl 9. 4 4 Was	hplece (State or Foreign untry) hington DC
	Maryland f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince (	Georges	10c. City, Towr		cation							10d. Inside City Limits 1 Yes 2 No
	h with the 13a or 28a-	al Director	10e. Street and Number 20713 Aquasco	Rd.			10f. Zip	Code	2060	8			ten of What Co JSA	untry?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. Is marked other than "natural", or Itams 23e or 28e-f show aumatic event, the Marical Examina must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 XN If Yes, Give Year or Dates:			Vas Deced f Yes, spec	_		gin? (Spe , Puerto	cify Yes or No Rican, etc.)		4. Race - Ame Black, White Specify: B	
Maryland 21215-0036	l within 72 ho iene. r than "natur ha Medicul	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		+)	(Give	lent's Usua kind of wor DO NOT us hani	k done d e retired,	luring most	t of worki	ng		od of Business/	
land	od all all	To Be C	17. Father's Name (First, Middle, Last)  Leroy Davis								(First, Middle,			
	is 1 and 2 should of Health and Men item 27 le marke other traumetic		19a. Informant's Name/Relationship (7  Jeanette Davi:				-					-	Town, State, 2 1D 206	
altimore,	Pages 1 and 3 nent of Health ant: If Item 27 ury or othar tr.		20a. Method of Disposition 1	Removal from State	20b. Place of cemeter Resul				e) N		22,05		eation - City or inton,	
Balti	permit. Page Department of Important: If any Injury or once.		21. Signature of June 11 ervice Liter	See )	151	22 A	. Name an	Addres Fu	s of Facilit nera	у 1 Но	ome, A	quas	sco, M	D 20608
	Physician		23a. Part 1. Enter the disease, or comy shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused one cause on each lin	θ.									Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence	of):						-		
8760,	ate be executed hysician and he burial-transit	al Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence									
.O. Box 687	death certificate e attending phy d for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 🗌 Fetal death		Ectopic pr					2	3d. Date of del Month	ivery Day Year
S, D	es this gned be de	by	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	n the u	nderlying c	ause give	en in Part I			obacco us		o the cause of death?
Vital Record		Completed									24a. Was autor perfo 1 Yes	rmed?	prior to death?	utopsy findings available completion of cause of
Vita	nysician: Th nis certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ∰ No	Hospital:				Othe			(Check only o		□Other (Spe	
of	ding PI h. After th funeral	11- 4	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injur (Month, Day	y 28b.	Time of Injury		8c. Injury Work	at at		28d. Describe I			ciry)
Division		Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, fa c. (Specify)	arm, str	eet, factory	, office			28f. Location (S City or Tox		d Number or Ru	ural Route Number,
	To the Hospital or within 24 hours after To tha Funarai Dir. completely filled in I	edical		nysician: To the best on niner: On the basis of and manner sta	examination an									
	To the I within 2 To tha I	M	29b. Signature and title of certifier						number				signed (Monti	
			Shoul ffix. 30. Name and address of person who	completed cause of de	eath (Itam 23a)	Tvna	Print) C	150	286	2		NOU	EMBGA,	16,2005
2	DBI		ROAD SUSTE	3, LANK	1 April 20d)	HO.	207	706	or H	# 77K	MIND,	48.	5/ G/CG	GW BG CT
	St Regist	ate rar	ROAD. SUSTE /9 31. Date filed (Month, Day, Year) NOV 17	2005 32. Resistra	ar's Signature	14	berte	,						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** November 11, 2005 12:15 A M Madelyn J. DiCocco /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert County | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year Sept. 21, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Year) 1 □ M 27 F Yrs. 1928 Pennsylvania Director 197-22-5511 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "naturel", or Items 23s or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No MD Calvert County Owings Direct 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20736 8855 Falling Leaf Drive U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Retail Manager Candy Store 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked other any injury or other treumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Anastacia Biller John George Tlumack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8855 Falling Leaf Drive, Owings, Maryland 20736 Sandra Morgan (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. 13. 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Lee Crematory matory 2005 Clinton, Maryland
22. Name and Address of Facility Lee Funeral Home Calvert, P.A. 21. Signature of Fund 3 Service Licensee 8125 Southern Maryland Blvd., Owings, MD 20736 Michael W. Bee 23a. Part1. Enter the disea of, or complications shock, or heart failure. List only one cause or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** IC CARDIAL DISEASE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 980 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ō Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by ificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1□ Yes 25 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 X EP/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funerel L Hospitel 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29c. License number 29b. Signature and tit certif 29d. Date signed (Month, Day, Year) D30583 November 14, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3508 Old Silver Hill Road, Suitland, Maryland 20746 John VanDam, M.D.31. Date filed (Month, Day, Year) 32. Registras Signature State 2005▶ Registrar

		-	State Registrar	te of Maryland	/ Department of F Certificate of	Death	Reg. No.	39151
	Physicia /Medic	an	1. Decedent's Name (First, Middle, Last)  Marissa Ka	IT Dun	kirk	2. Date of D Month	19 am	
14	Examin Funeral Director	er	4a. Fecility Name (If not institution, give street at Terry Teduca.  5. Social Security Number 6. Sex 1 M 2	Center 7. Age (In yrs. las	r Balti	r Location of Death  MOFE  If Under 24 Hrs. Hours Min. (Month, C	4c. County of Dee Baltime inth av. Year) 9. Bir	
	TO .		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
	Ba-f sh	Director	WV BERKELEY		MARTINSBURG			1 □ Yes 2 □ <b>X</b> ( <b>X</b> )
	3a or 2		10e. Street and Number  93 PETERSBURG LAN	E	10f. Zip Code	5401	10g. Citizen of What Co	ountry?
36	s after deat	by Funeral	1 Never Married 2 Married 1 If Y	s Decedent Ever in U.S. led Forces? Yes 2 XNo es, Give Ir or Dates:	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕱 No	lispanic Origin? (Specify Yes or Nan, Mexican, Puerto Rican, etc.)  Specify:	Specific	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene. Departments if tiern 27 is marked other than "naturel", or items 23a or 28a-f show many injury or other treumatic svant, it a Medical Examinar must be notified at angles.	Completed t	15. Decedent's Education (Specify only highest grade comp Elementary/Secondary (0-12) Col		16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retired N/A	during most of working	16b. Kind of Business	
Maryland 2	uld be filed w tental Hygie rked other t tic svsnt, IL	To Be Co	17. Father's Name (First, Middle, Last) SEAN P. DUNKIRK			18. Mother's Name (First, Middle STEPHANIE		
Mary	and 2 should salth and Men n 27 is marke ser treumatic		19a. Informant's Name/Relationship (Type, Prints SEAN P. DUNKIRK/FAT			and Number or Rural Route Num LANE, MARTINSB		
Ф	Pages 1 ar nent of Hea ant: If item ant: or other		20a. Method of Disposition 1 ☐ Burial 2 ② Oremation 3 ☐ Remova 1 ☐ Donation 5 ☐ Other (Specify)	I from State	ce of Disposition (Name of netery, crematory or other plac THSBURG CREMATORY	2005 Date 2005	20c. Location - City or SMITHSBUR	
Balti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee	lower	22. Name and Addre BROWN FUNER	ss of Facility AL HOME, P.O. BOX 8 MARTINSBURG, WV		G ST.,
	Physician /Medical Examiner		regulting in death)	e on each line.  Ongeniue to (or as a conseque	tal Pneu	emonia	arrest,	Approximate Interval Between Onset and Death Anour S
38760,	irate be executed physician and sthe burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	retermine to (or as a conseque	Premat	ture Ruptu	re of New	23 days
Box 6	ath certil ttending or use a	Physician/Med	in the past 12 months?	es, outcome of pregnand Live birth 2∏Fetal of Pregnant at time of dea Unknown	death 3 Ectopic pregnancy	/	23d. Date of de Month	livery Day Year
σ	juires that the de n signed by the a lid be detached f	by	Part II. Other significant conditions contributing	ng to death but not result	ting in the underlying cause giv		tobacco use contribute t ]Yes 2□No 3□P	
	The law requires rate has been sign page 2 should be	Completed				24a. Wa aut per 1 X Yes	opsy prior to death?	utopsy findings available completion of cause of
	ding Physician: Th h. After this certificate funeral director, pag	tion; To Be	Natural 5 Pending	inpatient ZLE	R/Outpatient 3 DOA Other Properties of Linguity M 1 DOA	26. Place of Death (Check only ter: 4 Nursing Home 5 Re: y at k?  Yes 2 No		ocify)
Division	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	a Could not be	. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office		(Street and Number or Rown, State)	iural Route Number,
	To the Hospital or A within 24 hours after to the Funerel Directompletely filled in by	edical (	(Check only 2 Medical Examiner: Or			me, date and place, and due to th opinion, death occurred at the time		
)	To th within To th comp	Me	29b. Signature and title of certifier  Renew Eller	tox HD	29c. Licens	3573	29d. Date signed (Mon	-
	4/ /		30. Name and address of person who complete RmN5WG8, 22 Se	od cause of death (Item :	23a) (Type, Print)	ver Ellen Bo	XTID	1 21201
101	Str	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	THE DIFFET	Daitimore	· narylan	na 21201

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

						Certific	ate of	Death		Reg. No.	005	3915
	Physici	an	Decedent's Name (First, Middle, Last)	0.10	c n ± L			•	2. Date of D Month	eeth Dey	Year	3. Time of Death
4	/Medic	al	Shirley	EVE	1611					ber 11,		7:40 PM
7	Examin	er	4a Fecility Name (If not institution, give s Heartland Health		10			4b. City, Town, or	Location of Dear		ty of Deeth	
			5. Social Security Number 6. Sex		n yrs. lest bir	thdev) If U	nder 1 Year	Aledphi	. R Date of Ri		ce Geo	
	Funeral Director			1M 2□ 32		Yrs. Mon			. (Month, D	24, 197	9. Birthpla Countr Wash	ace (State or Foreign ry) ington DC
	yend Mark		10a. State 10b. County	10	c. City, Town	n or Location					10	d. Inside City Limits
	Man	ţ	Maryland Prince Ge	orge	Temple	Hills	3					1 ☐ Yes 2 ☐ No
	A 28	5	10e. Street end Number				Zip Code			10g. Citizen of	What Counti	ry?
	23a C	aiD	2116 North Anvil L	ane			20748	3		United	State	S
21215-0020	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural; or items 23e or 28e-f show any Injury or other traumatic event, fra Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 22 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	r in U,S.		ecedent of I specify Cub s 2 No	Hispanic Origin? (San, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		ce - America ck, White, et fy: Afro-	
2-0	72 hc	Completed by	15. Decedent's Educ	cation	16a.	Decedent's U	Jsual Occup	pation	rkina	16b. Kind of E	lusiness/Indu	ıstry
21	ig a g	힏	Elementery/Secondary (0-12)	College (1-4or 5+)				during most of wo d)		Vanie	Unifor	rm Pro-
2	led w lygier Ner th	S	Twelve		_   Sp	ecial	Polic	e Office		tectio		vices
anc	be fi	Be	17. Father's Nerne (First, Middle, Last) Thomas Everett						me (First, Middle		•	
Maryland	should be fend Mental Fend Mental Fends Mental Fends of marked of tumatic eve	은	19a. Informant's Name/Relationship (Typ	- Dia	405	14-11'- A 11	(0)		y Elaine			
	end 2 s ealth en n 27 ls r		Michael Ontario R	yals/Husbaı	nd	3107 N	aylor	Rd SE,				
Baltimore,	permit. Peges 1 end 2 should be filed withir Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than any Injury or other traumatic event, tra Mana.		20a. Method of Disposition    ↑ ☐ Burial 2 ☐ Cremation 3 ☐ Re  4 ☐ Donetion 5 ☐ Other (Specify)	emoval from State		Disposition (y, crematory) In Cem		1.	November 19,2005			
Balt	permit. Depertulmporta any Inji		21. Signature of Funeral Service License	9		22. Name	and Addre	ess of Facility Ro Hope Rd	bert G.	Mason F	uneral	L Home,
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only	ations that caused the	death. Do n	not enter the r	node of dyir	ng, such as cardia	c or respiratory a	rrest,	1	Approximate Interval Between
The state of the s	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Ca	•	oles		0	Lie	lure	Ö	Onset and Death
	sit ad	iner	_ b	Pl	to (or as a c	consequence	oh):	MIU				
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68760,	n certificate to anding physic use es the b	Medical	that initiated events resulting in death) Last	Due	N IIII	onsequence	of):	AIT	) (		1	
Вох	eeth ce ettendii I for use		d.	170	· ·	N ( CC		12				
	of the dea by the et	Physician/	Part II. Other significant conditions cont	ributing to death but no	t resulting in	the underlyin	ıg cause giv	en in Part I.	23b. Did	tobacco use co	ntribute to t	he cause of death?
°, 0	es thet thigned by the detection	by Phy							1 🗆	Yes 2□ No	3 Proba	bly 4□ Unknown
Vital Records,	e faw require hes been sig je 2 should b	Completed t		1,					24a. Was	an autopsy rmed?	availa	e autopsy findings able prior to pletion of cause seth?
<u>~</u>	The law sete hes to pege 2 s	000							10	Yes 2√⊡ No	101	Yes 2□ No
/Ita	delan: The		25. Wes case referred to medical examiner?					26. Plece of Dea	ath (Check only o	nne)		
5	hy B is	ို	1 ☐ Yes 2 ☑ No	ospital: 1   Inpatient	2□ ER/Out		DOA Oth	#£ZEIYUISING F	lome 5 ☐ Resi			
ב	After Uner	ö	27. Manner of Deeth 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye	28b. T In	ijury	28c. Injun Work		28d. Describe	now injury occur	red	
Division	or Attending efter death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S		m, street, fac		Yes 2□No	28f. Location (: City or Tox	Street and Numb	per or Rural F	⊰oute Number,
	To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edicai Ce	29a. Certifier  (Check only one)  15 Certifying Physic Check only 2 Medical Examine	cian: To the best of my er: On the basis of exa	knowledge,	death occurr Vor investigat	ed at the tim	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and ma	anner as state	ed. ne cause(s)
	within 2	ĕ ∑	29b. Signature and title of certifier	and menner stated.			29c. License	e number		29d. Date signe	d (Month. Da	ıv. Year)
	F 3 F ŏ		· (10.	1100	LAT	7.	1	0 001		Novembe:		
^	(2)	-	30. Name and address of person who com	noleted cause of death	/V 1	Type Print1	0	0 4 70	*			DC 20001
1	(3)		31. Date filed (Month, Day, Year)	A	RUA	J A	PA	SPUL	A	106 I	RUIN	GST
	Stat Registra	е, ,	NOV 2. 1 2005	3 Registrer's S	*	had!						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 14, 2005 **Physician** 2:20 Pm H. Efros Rollee /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Rockville Hebrew Home of Greater Washington 8. Date of Birth (Month, Day, Year) Jan. 17, 1925 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplece (State or Foreign Country) New York 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** Months 1 ☐ M 2√2 F 80 294-22-1509 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f ehow traumatic event, it a Medical Examinar must be notified at 1 XYes 2 □ No Bethesda Montgomery Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö U. S. A. tems 23a 4978 Sentinel Drive, # 306 20816 death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married ŏ White 1 ☐ Yes 2 XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than College (1-4or 5+) 5+ Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other traumatic event, Item Law Lawyer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Grave Hurewitz Jerome Herbert ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4978 Sentinel Drive, # 306, Bethesda, Md. 20816 Seymour Efros - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Demoval from State King David Mem. Garden 11/16/05 Falls Church, Virginia \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels, Inc
II/O Rockville Pike, Rockville, Maryland 21. Signature of Funeral Service Licensee 20852 Sonald ( 23a. Pert1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of) the attending physicien Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No jo Year Day 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$€ No 3 Probably 4 Unknown 1 Tes certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 □ NO or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospitat within 24 hours at To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examin . So the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 2 ☐ Medical Examin 29b. Signature and title 29c. License number 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) November 14, 2005 Allan Ferrel1 **Physician** 3:15P. Richard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 6611 Wells Parkway 4b. City, Town, or Location of Death University Park **Examiner** Prince George's 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April28,1926 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Hours Days 79 Yrs. California 564-22-7760 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location show 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Illiu M. dical Examinet must be notified at Yes 2 No Maryland Prince George's University Park Director 10f. Zip Code 10g. Citizen of What Country? 6611 Wells Parkway 20782 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? to Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1□Yes 2 No White Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Professor University of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Robert M. Ferrell Elsie Hopper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Miriam L. Ferrell -wife 6611 Wells Parkway University Park, Md. 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory11/15/2005 | Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Mar Maryland20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute Renal Failure 1 month Physician /Medical Due to (or as a consequence of): **Examiner** Multiple Myeloma 5 years Sequentially list conditions, if any, leading to immediate cause. Errier Uniderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ō in the past 12 months? 4 Pregnant at time of death 5 Other (specify) I□Yes 2□No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 □Other (Specify) 10 28c. Injury at Work? 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification:

requires that the death certificate be execu Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified funeral director,

the Maryland

Baltimore, Maryland 21215-0036

Injury 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 🗡 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number DC20542

29d. Date signed (Month, Day, Year) November 15, 2005

30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Joseph Catlett, MD Washington Cancer Institute, #2151 110 Irving St., NW Wash. DC20010

State Registrar 31. Date filed (Month, Day, Year) 2005





MABELON VICGINIA Green

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 21 per fh g850 12-5-05 yt State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 21 Month Yeer **Physician** 20 Madelon Virginia Green /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Boon Shor o M b William If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1914 WAShington heed Tome Ahrne 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🛣 F Yrs. 91 Director 215-42-3928 Washington, MD February 17, Usual Residence of Decedent death with the Maryland 10c. City, Town or Location Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic event, the Medical Examinat must be notified at 90ce. 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 🛣 No Maryland Washington Boonsboro Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8507 Mapleville Road 21713 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 Ž No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: 3 Ø Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) d 2 should be fi h and Mental H 7 Is marked ot Henry C. Baker Edith J. Fogle 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If item 27 Is (Son) 3733 Grovewood Rd. Richmond, VA 23234-4862 Kenneth W. Green Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State November ' 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 22, 2005 Smithsburg, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home Jeffrey Lee Davis per dvr 12525 Bradbury Ave. Smithsburg, Maryland 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Athrosclrotic Cardiovascular Disease 20 years /Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease 20 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Box 68760. clan/Medical as the l IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) detached Records, P.O. Physi 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas autopsy performed?

1 Yes 2 X No Division of Vital funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner: Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Certification: al or Attending P after death. 1 🖾 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 28, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar Dr. Kila....
31. Date filed (Month, Day, Year)
UEC 0 5 2005

Dr. Khalid Waseem 1126 Opal Crt. Hagerstown, Maryland 21740

32. Resistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 14, 2005 **Physician** David Kenyatta Glover November 1:35 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 25 yrs 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Days Hours Min. Yrs. Director 212-08-1075 12/2/79 Wash., D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar recognitions on the page. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Capitol Heights P.G. Md. Y Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 14 Daimler Drive U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Tes X No Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Home Improvement Elementary/Secondary (0-12) College (1-4or 5+) 12th Stock Clerk Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Jones Kenneth Glover 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Martha C. Glover/Mother 14 Daimler Drive, Capitol Hgts., Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/19/05 Mt. Olivet Cem. Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 acig 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bacterial **Physician** Meningit unknow-/Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) signed by the a ld be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No should should 3 Probably 4 dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 Yes 2 1 No 1 Yes : After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Inpatient Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43446 Rosalm Faralli 11.1500 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Archit 3-41 Slun Spring ND 20902 FARAHIFAR MO ROINTAN 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 1 8 2005 Registrar

		•	For State Registrar	State of	Marylan		artment of H		Mental Hyg	ieĝe	5 3	9157
			Decedent's Name (First, Middle, Last)						2. Date of Deat Month		V	3. Time of Death
	Physici /Medic		Chester Miller	Garner					Novembe		Year 2005	9:10 a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give				4b. City, Town, or		th	4c. County	of Death	
			Genesis Elderca  5. Social Security Number 6. Sec		nter . Age (In yrs. I	act hirthday)	LaPlat		9 Date of Birth	Char		(6)
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	D		Usual Residence of Decedent						riay 27	, 1925	r emm.	<u>syrvania</u>
	arylan show	_	10a. State 10b. County			, Town or Lo			/		100	d. Inside City Limits
	Ba-f	Director	Maryland Charle	S	I	aPlat						1 Yes 2 No
	a or 2	Ω	10e. Street and Number 6358 Nelson Dri	170			10f. Zip Code	c	1	0g. Citizen of \		у?
	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show the Modeal Exertiner mast be notified at	by Funeral		12. Was Decede	ent Ever in U.	S. 13. V	2064 Was Decedent of Hi		Specify Yes or No-	U.S.A	xe - Americar	n Indian,
9	or Iter	Fu	1 Never Married 27 Married	Armed Forc	☐ No	1	Was Decedent of Hi f Yes, specify Cuba		to Rican, etc.)		ck, White, et	ic.
21215-0036	ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Date			1 □ Yes 2 X No	Specify:		Specify	Wh:	ite
5-	"natu	Completed	15. Decedent's Edu (Specify only highest grad			(Give	dent's Usual Occupa kind of work done do DO NOT use retired.	uring most of wo	orking	16b. Kind of 8	usiness/Indu	ıstry
12	withir iene. than he M	dmo	Elementary/Secondary (0-12)	College (1-4	or 5+)		rpenter		Ţ	J.S. G	overi	nment
0	filled Hygid other ent,	Be Co	17. Father's Name (First, Middle, Last)				iz pencer		me (First, Middle, M			Interre
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan ardment of Heath and Mental Hygiene. ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Wideal Exeminer must be neillised at a.	To B	Pharis S. Garr	er				Anna	May Mil	ller		
lary	2 should and Men is marke raumatic		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailin	g Address (Street a	nd Number or R	ural Route Number,	City or Town,	State, Zip C	ode)
	1 and Health tem 27		Dorothy Smith G	arner				Dr.,	LaPlata,	T		
Baltimore,	ges 1 t of H if Itel		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from St	ate C	emetery, cren	sition (Name of natory or other place	Nov.16	2005	20c. Location -	City or Tow	n, State
Ë	t. Partmen		`4 □Donation 5 □ Other (Specify)		Mar	утапс	vetera	ns cem	erery (	Chelte	nham	, Marylar
Ва	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		21. Signature of Funeral Service Licens		MOOG	7 V	Villiams	Funer	al Home,	P.A.		20640
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	cations that cau	MO06	n. Do not ent	er the mode of dying	thorne	al Home, Rd., Ir	ndian est,	Head,	Md Approximate
	Physician		Immediate Cause (Final		Alline.		moun					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		r as a consequ		3100010					Mond/ha
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	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C 1744	010.7C			to con t	T1504. #	Dence	2.	y co-c
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	es on on on	Completed by Physician/Me	Part II. Other significant conditions con	ntributing to dea	th but not resu	ulting in the ur	nderlying cause give	en in Part I.				cause of death?
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a	Th ate pag								1 ☐ Yes 2	No.	1 Yes 2	.□ No
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of	y Physer this eral di	-	27. Manner of Death	1 Ing	Injury	28b. Time of			Home 5 Reside			
ion	Attending or death. ector; After by the fune	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month,	Day Year)	Injury		:? ∕es 2 □No				
Division	r Atte er de recto by th	Certification:	3 Suicide 6 Could not be determined	28e. Place o	f Injury - At ho	ome, farm, str	eet, factory, office		28f. Location (Str. City or Town		er or Rural I	Route Number,
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	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director; Atter completely filled in by the funer	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	<b>ner</b> : On the bas	is of examina	wledge, death tion and/or in	n occurred at the tim vestigation, in my op	e, date and plac sinion, death occ	e, and due to the ca urred at the time, da	iuse(s) and ma ite and place,	inner as stat and due to t	ted. he cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manne	or stated.		29c. License	number	29	d. Date signe	d (Month, Da	av, Year)
	To To Control		Danne	4/12)	all	June J	7 0:	206	29	111	1111	50
•			30. Name and address of person who or	ompleted sause	of death (Item	1 23a) (Type.	Print)		- k - l -	~ 1	171	-5
N	18441		GIENPORE L	NP	20-7-62	1.1	V. CIN	CTA.	ORF, V	nd.	20	603
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Physician	Decedent's Nar	me (First, Midd	le, Last)		,	41		Death	Mont		Day	Year	3. Time	
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ļ	11. Marital Status		Arme	Decedent Ever i	04.0	If Yes, spe	cify Cuba	an, Mexican, Pi	(Specify Yes of Jerto Rican, etc.	or No- c.)		ce - Americar ck, White, et		
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	RUSSELL	L. HUTZ	ZELL					CLARA	SMITH					
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Gary N. Hornbaker, Sr./Son    12218 Big Pool Rd., Clear Spring, MD 21	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to	
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25. Was case referred to medical examiner?  1 Yes 2 No  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  27. Manner of Beath  1 North and Suicide  4 North, Day Year)  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  M 1 Yes 2 No  28d. Describe how injury occurred	I Route Number,
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month)	// Route Number,
SAMUEL CHAN, MO D36653 May. 28; 2	// Route Number, tated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)	// Route Number, tated. the cause(s)
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State Registrar  State Registrar	// Route Number, tated. the cause(s)

HELEN CATHERINE

			1 - For State Registrar	State	of Maryland	d / Depa <i>Cei</i>	artment of H tificate of L	ealth and Death	Mental Hygi	ene 005	39161
	Diam'r.		1. Decedent's Name (First, Middle	, Last)					2. Date of Death		3. Time of Death
	Physic /Medi		BETTY MARIE HI	VION					Month NOVEMBER	Day Yea 25, 2005	
	Examir		4a. Facility Name (If not institution	give street and no	umber)		4b. City, Town, or	Location of Deat		4c. County of De	
	di		3841 TWIN OAK D	RIVE			EDGEWATE	R		ANNE ARI	INITACIT
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year	If Under 24 Hrs			irthplace (State or Foreign
234	Director		579 42 3225	1□M 2₩F	72	Yrs.	Months Days	Hours Min.	JAN. 20, 1		SHINGTON D.C
	D >		Usual Residence of Decedent		140.00					700 111210	MILITORY D.C
	aryla ehov	_	10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Limits
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	ter death with tems 23s	20	3841 TWIN OAK DE				21037		U	NITED STA	ATES
	ar da	Funeral	11. Marital Status	Armed F			Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	14. Race - Arr Black, Wh	nencan Indian,
36	s aft	by F	1 ☐ Never Married 2 X Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, G		1	☐ Yes ※☐ No	Specify:		Specify:	
215-0036	be filed within 72 hours after death with the Maryland ital Hygiana. Id other then "natural", or itema 23a or 28a-1 ehow event, tre Medical Exarteter must be notified at	ba		Year or I	Jates:	16a Daniel				WE	IITE
<del>ل</del> بې	1 . na	Completed	15. Decedent (Specify only highes	grade completed		(Give	ent's Usual Occupa kind of work done di OO NOT use retired)	uring most of wor	king	3b. Kind of Busines	s/Industry
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Maryland	should be nd Manta n marked umatic ev	2	JOHN H. BRECHT  19a. Informant's Name/Relationsh	in (Type Print)		10h Mailin	Addraga (Street a	SADIE W	R <b>IGHT</b> ral Route Number, (		
2	and 2 :	1	DONALD HINTON/H								
മ്	Haa Haa		20a. Method of Disposition	IUSBAND	20b. Pla	3641 ace of Dispos	TWIN OAK	DRIVE .	EDGEWATER Date 20	MD 2103 c. Location - City o	
ᅙ	os O		1 Burial 2 Cremation		State Ce	metery, crem	atory or other place	· !		c. Location - City o	r rown, State
altimore,	artme artme ortan Injury	1	4 Donation 5 Other (Sp		CED	AR HII	L CEMETER	RY 11-2	3-05 SI	M, COALTEE	D
Ba	parmit. Page Dapartmant Important: If any Injury o	: 5	Plat 1	1.1.			Name and Address	GEX	ORGE P. K	ALAS FUNE	RAL HOME
			23a. Part1. Enter the disease, or shock or heart failure. List of	omplications that	caused the death	29	73 SOLOMO	NS ISLAI	ND ROAD EI	GEWATER,	
22			SHOOK, OF HOME HAILONG. LIST C	iny one cause on i	gaptori iirie.			, such as cardiac	or respiratory arres	t,	Approximate Interval Between
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_	Aftar funa	5	1 Natural 5 ☐ Pending		th, Day Year)	8b. Time of Injury	28c. Injury a Work?		28d. Describe how	injury occurred	
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DIVISION	or A aftar Direction by	Certification:	4 ☐ Homicide determin	ed 286. Place	of Injury - At hom ng, etc. (Specify)	ie, farm, stree	et, factory, office		28f. Location (Stree City or Town, S	it and Number or Ri State)	ural Route Number,
3.	purs surs saral		29a. Certifier Certifying	De la la la la la la la la la la la la la							
:	to the hospital of Attending within 24 hours after death.  To the Funeral Director: Attal completely filled in by the funeral Director.	edical	(Chack only 2 Medical E	Continued. On the Di	dois of graffilliano	edge, death in and/or inve	occurred at the time, stigation, in my opin	, date and place, non, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	s stated
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene [] 5 1 - For Stata Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2005 **Physician** November 9, 10:50 FM M Rosa P. Harris /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro Prince George's 312 Peribertan Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. July 14, 1912 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 200 F Yrs. 579-16-5942 93 Washington, D.C. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show other then "natural", or items 23a or 28a-f showent, the Medical Examiner must be notified at D.C. Washington XXYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20019 4008 Meade Street, N.E. U.S.A. Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2X No δ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Department of Defense Realty Specialist it of Health and Mental Hyg If item 27 is marked oths or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James H. Plater Mary F. Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
312 Pemberton Street Upper Marlboro, Maryland 20774 Ms. Catherine P. Fisher (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or once. Arlington National Cemetery November 22, 2005 Arlington, Virginia ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ix, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2XXNo 23d. Date of delivery atten for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signer should be d þ Completed 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒No 24a. Was an autopsy performed? res 2 No certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Particle 1st 1st 28d. Describe how injury occurred ٩ 1 ☐ Yes 2 ☐ No After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 1 🔀 Natural 5 Pending death. neral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 November 15, 2005 aro 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Weltz, M.D. 7525 Greenway Center Drive Greenbelt, Maryland 20770 31. Date filed (Month, Day, Year)
NOV 1 8 2005 3 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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		1 - For State Registrar	State of Ma		partment of H ertificate of L			giene Reg. No. 0 0 5	5 39164
Physic		1. Decedent's Name (First, Middle, La	)		HENK	24	2. Date of Dea Month	Day	3. Time of Death
/Med Exam	iner	4a. Facility Name (If not institution, giv  WASHINGTON A  5. Social Security Number 6. S	DVENTIS.	T HOSPITA	TAKON	Location of Death  A PARK  If Under 24 Hrs.			TOOMERY.
Funera Directo			/. Age	76 Yrs.	Months Days	Hours Min.	8. Date of Birth January	13° 1929	9. Birthplace (State or Foreigr Country) Virginia
Maryland e-f show	tor	10a. State 10b. County Maryland Prince Ge	orge's	10c. City, Town or		nital Heigh	ts		10d. Inside City Limits 1 1 Yes 2 ☐ No
3e or 28e	I Direc	10e. Street and Number 612 Millwolf Driv	æ		10f. Zip Code	20743		10g. Citizen of Wh	
partilling is, Ivial yial to Z.I.Z.1.2-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other traumatic event. In Medical Experiment contractions of the provided any injury or other traumatic event.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	ever in U.S. 1:	3. Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc. Black
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aryland 2 should be filed and Mental Hygis s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last, James P)				18. Mother's Nam	e (First, Middle, Amie P	Maiden Surname,	)
;, Mary and 2 shou ealth and M n 27 is mar ner traumat		19a. Informant's Name/Relationship ( Mr. Charlton E. Henry		19b. Ma 612	uiling Address <i>(Street a</i> Millwolf Dri	und Number or Ryi ve Capital	Heights,	r, City or Town, S. Maryland	tate Zip Code) 20743
Saltimore, bernit. Pages 1 ar Department of Hea mportant: If Itam sny injury or otha		20a. Method of Disposition  1  Burial 2 Cremation 3   4  Donation 5 Other (Special		cemetery, c	position (Name of rematory or other place ce Crematory,	e)	Date Der 17,200	Y 72	Sity or Town, State Sville, Maryland
parmit. Pepartm Departm Importar		21. Sina are of Funeral Service Lice	•		22. Name and Addres 4339 Hunt Pl			neral Hom	e, Inc. 0019
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The ate h	Completed						24a. Was a autop perfor 1 🗆 Yes	med? de	ere autopsy findings available for to completion of cause of lath? Yes 2 2 10
n Of ng Phys ter this neral di	tion: To Be	25. Was case referred to medical examiner?  1 ∠ Yes 2 No  27. Manner of Death  1 ∠ Natural 5 Pending 2 Accident investigatio	Hospital: 1 Inpatie 28a. Date of Injur (Month, Day	y 28b. Time	of 28c. Injury Work	26. Place of Deat  ar: 4 □ Nursing Ho  ( at  (?)  Yes 2 □ No	ome 5 Resid		
Division tal or Attending is after death. al Diractor: Attented ed in by the fune	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm,	street, factory, office		28f. Location (S City or Tow	treet and Number n, State)	r or Rural Route Number,
To the Hospital within 24 hours a To the Funeral is	edical (	29a. Certifier 1 ☐ Certifying Pl (Check only 2 ☐ Medical Exa-	hysician: To the best ominar: On the basis of and manner sta	examination and/or	eath occurred at the time investigation, in my op	e, date and place, pinion, death occur	and due to the d red at the time, o	cause(s) and mand date and place, and	ner as stated. Indicate to the cause(s)
To th within To th	Me	29b. Signature and title of certifier	- MD		29c. License			-	(Month. Day, Year)
e (2)		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	pe, Print)	PARRAII	AVE	Takan	0, 2005. A PARK Md.
S Regis	tate	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	and a	- TICK OLL	AVE.	I ANOM	<u> </u>

State of Maryland / Department of Health and Mental Hygiene 05 For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) November Day 9 2005 **Physician** 8:55 p M Hines Jr. George James /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 11330C Clemsonville Rd. Union Bridge | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | Oct. | 14. 1963 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 XM 2 ☐ F 42 Yrs. 215-80-0366 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show traumatic event, the Medical Examinar must be notified at 1 Tes 2 No Union Bridge Director MD Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: if item 27 is marked other than "---" any injury or other traums." ö 11330C Clemsonville Rd. 21791 U.S.A. Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dairy Farmer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fern Stevens George J. Hines Sr. ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11330C Clemsonville Rd., Union Bridge, MD 21791 Cindy F. Hines - wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rocky Hill Cemetery | 11/14/2005 nr. Woodsboro, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licenses 404 S. Main St., Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 8 00 **Physician** YOLK SOC Eumor disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Š 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ № 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ro 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 WJL · 45 1x00 15,2000 10146 26 30. Mayne and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD 21701 Rausch 31. Date filed (Month, Day, Year) Elsen & Spark 2005 Registrar

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Н	Physici	an	1. Decedent's Name (First, Middle, Last)  Marie Elizabeth Holden			2. Date of Death Month November		2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	cation of Death	NOVERBEL	4c. County		23:30PM <sup>™</sup>
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	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days H	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,			ace (State or Foreign
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	or 28	Director	10e. Street and Number	10f. Zip Code		10	g. Citizen of	What Countr	y?
	ath w	ral	7401 Willow Road	21702			U.S		
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Maryland 2121	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 le marked other than "natural", or Items 23a or 28e-f show other treumatic event, The Medical Examiliar must be notified at	-		Mailing Address (Street and					Code)
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Baltimore,	0 0		20a Method of Disposition 20b. Place of	Disposition (Name of , crematory or other place)		Date 2	0c. Location -	City or Tow	n, State
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Division of Vital Records, P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 Abrusr after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of cause (Disease or injury that initiated events resulting in death)  Due to (or as a consequence of cause (Disease or injury) that initiated events resulting in death)  Due to (or as a consequence of cause (Disease or injury) that initiated events resulting in death)  Due to (or as a consequence of cause (Disease or injury) that initiated events resulting in death)  Due to (or as a consequence of cause (Disease or injury) that initiated events resulting in death)  Due to (or as a consequence of cause (Or as a consequence of cause (Disease or injury) that initiated events resulting in death)  Due to (or as a consequence of cause of death)  Due to (or as a consequence of cause of death)  Due to (or as a consequence of cause of death)  Due to (or as a consequence of cause of death)  Due to (or as a consequence of cause of death)  Due to (or as a consequence of cause of death)  Due to (or as a consequence of cause of death)  Due to (or as a consequence of cause of death)	3 Dectopic pregnancy 5 Other (specify)  the underlying cause given in  26.  Datient 3 DOA Other:  Me of Lury M 28c. Injury at Work? 1 Yes  The street, factory, office  death occurred at the time, do for investigation, in my opinion  29c. License nur D164  Type, Print)  9th St., Freed	Place of Deat  Place of Deat  Nursing Ho  2 \( \text{No} \)  Interpretation of the place, in, death occurrence of the plac	23e. Did toba  1	23d. Dat Mo  24b. V  2	te of delivery inth Discribute to the autops or or to comp death?  er (Specify)  er or Rural Family and due to the autops of the comp death?	ay Year  cause of death?  cause of death?  ly 4 Uniknown  y findings available letion of cause of  No  Route Number,  ed.  le cause(s)

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Hollis 2348 13 2005 4a. Facility Name (I not institution, give street and number) November /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY MONTGOMERY GENERAL HOSPITAL OLNEY If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Days **Funeral** 1 □ M 2 🖾 F Yrs Director SEPT. 5, 1928 OHIO 578-34-2907 Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show traumatic svent, the Medical Examinar must be notified at Director 1 ☐ Yes 2X No MARYLAND MONTGOMERY SILVER SPRING 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö or items 23a 915 SNIDER LANE 20905 U.S.A. death Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ò If Yes, Give Year or Dates: WHITE 3 Widowed 4 Divorced "naturai", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene important: if item 27 is marked other than "nat any injury or other traumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING LIBRARIAN 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MARGARET ANTHONY GUARTNO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 915 SNIDER LANE, SILVER SPRING, MARYLAND 20905 BERNARD C. HOLLIS/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GATE OF HEAVEN CEMETERY 11/18/2005 SILVER SPRING, MARYLAND 22. Name and Address of Facility HINES-RINALDI FUNERAL HOME 21. Signature of Funeral Service Licensee udeura 11800 NEW HAMPSHIRE AVENUE, SILVER SPRING, MARYLAND 20904 23a. Part1. Enter the disease, or complications that caused the sath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Non Small Cell Lung Cancer **Physician** Metastatiz 4 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine the ettending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 1 Yes 2 No 3 Probably 4 Munknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 No Hospital or Attending Physicien: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA this After this funeral d 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the ů, 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 Ban November 14, 2005 10 MD060335 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Prive # 327 Olney , MD Prince Paul Bannen 18111 31. Date filed (Month, Day, Year) State 17 NOV 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** DONALD HASTINGS 0655 M L. 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Peninsula redical Cente Legional If Under 1 Year 5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Months Hours Delaware 68 Yrs **Director** 221-22-6663 Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ment or te marked other than "natural", or Itama 23a or 28a-f ahow other traumatic event, the Medical Exercities found be notified at Director Delaware Seaford 1 Yes 2 XNo Sussex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19973 US 25704 Woodbine Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give 1958-1964 Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after o Depertment of Heelth and Mental Hygiene. Importent: if item 27 is marked other than "natural; or item any injury or other traumatic event, the Modical Eventment 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator Chemical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rachael Hastings ဂ္ Raymond Hastings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25704 Woodbine St, Seaford, DE 19973 Clarabelle Hastings - wife Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Odd, Fellows Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/18/2005 Seaford, DE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fun ral Solvice Licensee 22. Name and Address of Facility cranston John A. Cranston Funeral Home P O Box 967, Seaford, DE 19973 Approximate
Interval Between
Onset and Death
10 21 05 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) muistiple Tranma Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the ettending physicien and hed for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 🖪 No 3 ☐ Probably 4 ☐ Unknown 1 Tes peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate hes autopsy performed 1□ Yes 2 HNO Attending Physician: completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one To Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 res 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Natural 10/21/05 death. 1 Yes 2 PNo 2 Accident 1400 Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Rt. 54 Gumboro DE Roaducy within 24 hours e To the Funeral ( Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To tha ! 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of centile 450497 14/05 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 100 E. Carroll Salisbury, md. 2180 31. Date filed (Month State 2005 Registrar

DHMH 17 Rev 1/2001

Hanting.

			1 - State of Maryland Registrar	/ Department of Health and M Certificate of Death	lental Hygiefie	39169
200	Physici		1. Decedent's Name (First, Middle, Last)  Trayvon Hurley	y	2. Date of Death November 11,	3. Time of Death 2005 0046 м
	/Médic Examin		4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital	4b. City, Town, or Location of Death Prince Frederi	ck 4c. County c	of Death alvert
18	Funeral Director		5. Social Security Number 6. Sex 1 □ M 2 □ F  7. Age (In yrs. las	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Nov.11,2005	9. Birthplace (State or Foreign Country) Maryland
	Maryland 8-f ehow	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, 1  Maryland Calvert	Town or Location Dunkirk		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the 3a or 28s	I Director	10e. Street and Number 2765 Chaney Road	10f. Zip Code 2 0 7 5 4	10g. Citizen of W USA	hat Country?
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or items 23e or 28e-f ehow any injury or other traumatic event, ite Medical Exertinal must be notified at ance.	by Funeral	11. Marital Status  11. Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.) 14. Race Black	- American Indian, k, White, etc. Black
Maryland 21215-0036	within 72 houene. Than "nature The Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of workil life. DO NOT use retired)  Never Worked	ng 16b. Kind of But	ŕ
land 2	uld be filed fental Hygi rked other tic event, I	To Be C	17. Father's Name (First, Middle, Last) Donald Hurley,	18. Mother's Name	$_{e}$ (First, Middle, Maiden Sumame $_{ m Buck}$	э)
, Mary	and 2 shore ealth and N ma 27 is maner trauma		Margo Buck-Hurley/Mother		nkirk, MD 20	754
Baltimore,	. Pages 1 tment of H tant: if ites jury or oth		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Hope UMC Cem. 11/1	7/05 Sunder	City or Town, State
Bal	permit Depar impor any in		21. Signature of Funeral Service Licensee  Hearly a. Sewell	22. Name and Address of Facility S 1451 Dares Beach Prince Frederick	, MD 20678	Approximate
8760,	Physician and bursari-transit	Ilcal Examiner	Sequentially list conditions.  Due to (or as a consequence of the conditions)  Due to (or as a consequence of the conditions)	naturity (17,5 Wee hor and delivery honopamnionitis/		Interval Batween Onset and Death  1-3 minute
O. Box 6	death certif e attending id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of dear	eath 3 □Ectopic pregnancy	23d. Date Mon	e of delivery tth Day Year
Δ,	es thg gned be de	by		ing in the underlying cause given in Part I.	23e. Did tobacco use contri 1 ☐ Yes 2 ☒No	ibute to the cause of death?  3 Probably 4 Unknown
of Vital Records,	The law ate has b page 2 sl	Completed			autopsy p performed? d	Vere autopsy findings available rior to completion of cause of eath?
on of Vita	ding Physician: The After this certificate funeral director, pa	To Be	25. Was case referred to medical examiner?  1  Yes  2 No  Hospital: 1 Inpatient 2 E	R/Outpatient 3 DOA Other: 4 Nursing Ho	n (Check only one) me 5 ☐ Residence 6 ☐ Othe 28d. Describe how injury occurre	
Division	il or Attendi after death. I Director: A d in by the fu	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At hom building, etc. (Specify)		28f. Location (Street and Number City or Town, State)	er or Aural Route Number,
	Hospita 4 hours Funeral	edical C		edge, death occurred at the time, date and place, in and/or investigation, in my opinion, death occurr	and due to the cause(s) and mar ed at the time, date and place, a	nner as stated. and due to the cause(s)
)	To the within 2 To the complet	×	29b. Signature and title of sortflier	29c. License number DOO2061		(Month, Day, Year) + 12005
			30. Name and address of person who completed cause of death (Item 2	Hospital Rd #205	2 Prince Fr	+/2005 ederick MD
\$ .	St. Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registra's Signatu NOV 1 7 2005			

ORIGINAL

			For State Registrar	State of	Marylan	d / Depa	artment o	of Health a		Re	eg. No.	005	391	70
DF	nysicia		1. Decedent's Name (First, Middl	e, Last)					2	. Date of Deat Month	h Day	Year	3. Time of	Death
	Medic	al .	Peter Joseph							ovember		, 2005	1:16	A <sup>M</sup>
E	xamin	er	4a. Facility Name (If not institution	-			Annapo	vn, or Location o	of Death			ounty of Death ne Arun		
E	neral		1411 Colonial  5. Social Security Number		7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Under		. Date of Birth			place (State o	or Foreign
	ector		151-28-5241	1 🛣 M 2 🗆 F	73	Yrs.	Months D	ays Hours	Min.	(Month, Day, 08/15/	1932	Illi	intry) .nios	
pg a			Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation						10d. Inside Ci	ity Limite
Aaryla	la Da	ō	Maryland Anne			napolis							1 [X] Yes	•
the h	age of	Director	10e. Street and Number	Arunuer	AIII	паротт	10f. Zip Co	de		1	0g. Citize	en of What Cou	untry?	
h with	at te		1411 Colonial	Manor Cour	t		2140	19		Ţ	JSA			
r deat	E G	Funerai	11. Marital Status	12. Was Deced	dent Ever in U	.S. 13.	Was Decedent	of Hispanic Ori Cuban, Mexican	gin? (Specif	fy Yes or No- can, etc.)	14	I. Race - Amer Black, White		
S afte		by Fu	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give			1 ☐ Yes 2 🔀				s	/6		
G 27275-0036 filed within 72 hours after death with the Maryland Hygiene, Institral or theme 23e or 28e-4 show	9	ed b		nt's Education	185.	16a. Dece	dent's Usual O	ccupation			16b. Kind	Whi		
21.2 Z dia 2	Medi	plet	(Specify only higher Elementary/Secondary (0-12)	est grade completed)  College (1-	4or 5+)	(Give	kind of work a DO NOT use r	lone during most etired)	t of working	'			,	
filed with	ā	Completed	12			Outdoo	or Amus					ertainm	ent	
E 8 2	0 A B	Be	17. Father's Name (First, Middle,	Last)						First, Middle, f	Maiden S	umame)		
Maryiand of 2 should be file the and Mental Hy	matic event, the Madical Examiner must be notified at	၉	Frank Joseph  19a. Informant's Name/Relations	shin (Tyne Print)		19h Mailir	ng Address /S	Anne	West		City or 3	Town State 7	in Code)	
Mary 2	Trace		Robert F. Jose				-	ders Wa			-			
stand Heelth	othe	ľ	20a. Method of Disposition	-	20b. F	Place of Dispo			Dat			ation - City or T		
Pages	iry or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		iale	odlawn		1	11/16	/2005 1	Balt:	imore,	MD	
Baitimore, permit. Pages t ar Department of Hee	any Inju		21. Signature of Funeral Service	Licensee				ddress of Facilit					al Homo	e
			23a. Part1. Enter the disease, of shock, or heart failure. List	complications that cat only one cause on ea	used the deat								Approximat Interval Bet	ween
Physi	ician		Immediate Cause (Final disease or condition		LUN	G C	ANC	ER					Onset and I	Death
/Med Exam	dical niner		resulting in death)	Due to (c	or as a conseq									
		e.	Sequentially list conditions,	b. — Due to (c	if as a consex	uence of):						-		
petn	ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>\</b>										
O, exec	nysicien end	Еха	resulting in death) Last	CDue to (c	or as a conseq	uence of):								
Box 68760, death certificate be executed	he br	lical		d										
certific	for use as t	Physician/Med	IF FEMALE:	23c. If yes, outc	ome of pregna	ancy						d Data -4 d-6		
Both	io io	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bir	rth 2 Feta	Ideath 3	Ectopic pregr Other (specif				23	d. Date of deli- Month	•	/ear
	tached	hysi	1 Yes 2 No 9 Unknown	9□Unkno										
	be det	by P	Part II. Other significant conditi	ons contributing to de	ath but not res	_		e given in Part I.		23e. Did tob	acco use	e contribute to	the cause of d	leath?
ord:	should t	ted	Coloolina	1 1874	,104	DI SICTO	76			1 🗆 Ye	s 2 🗆	No 3 Pro	bably 4 🗀	Jnknown
Records, The taw requires to	9 2 Sh	Completed								24a. Was a autops	n y	24b. Were aut prior to co	opsy findings ompletion of c	available ause of
The second	tor, page 2 s			==1						perform 1 Yes 2	No	death?	2 🗆 No	
of Vital Physician:	director, pag	o Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2	IED/Outpation	3 T DOA	Other		Check only on		□Other (Spec		
Phy S	Atter this funeral d	$\vdash$	27. Manner of Death	28a. Date o	f Injury n, Day Year)	28b. Time of		Injury at Work?		d. Describe ho			ny)	
VISION Attending	of fun	atio	2 1100.00	igation	i, Day rear)	Injury	М	1 ☐ Yes 2 ☐ i	No					
Division of Vital  Lor Attending Physician: after death.	in by the f	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	minad 288. Place	of Injury - At hig, etc. (Specif	ome, farm, str fy)	eet, factory, of	fice	28	f. Location (St. City or Town	reet and i	Number or Rui	ral Route Num	ber,
pital c	illed i		202 0 45						4 -1	d d				
To the Hospital	completely filled	Medicai	29a. Certifier 1 Certifyii (Check only 2 Medical one)	ng Physician: To the I Examiner: On the ba and mann	sis of examina	wiedge, death ation and/or in	n occurred at t vestigation, in	ne time, date an my opinion, dea	th occurred	at the time, da	ate and p	lace, and due	stated. to the cause(s	)
To the	ld woo	Me	29b. Signature and title of certific				29c. L	cense number		29	9d. Date	signed (Month		
			Sital	ノノニ			D	4169	8		11/1	4/2	200	
			30 Name and address of person	1 Homels		п 23а) (Туре,	Print)	Fense	du	y they	00,	ANN	2008 2008	2149
R	Sta Registr	te ar	31. Date filed (Month, Day, Year, NOV 1	6 2005 32. R	gistrar's Signa	ature	for the	,			/-	, , , , ,		

		-	For State Registrar	State of Mar		artment of h		d Mental Hy	giene )	39171
			Decedent's Name (First, Middle, Last)					2. Date of De Month		3. Time of Death
	Physicia /Medic		Nancy Jane Jaco	b				Novembe		005 4 А м
	Examin		4a. Facility Name (If not institution, give st			4b. City, Town, o			4c. County o	of Death ngton County
			109 East Hillcres		(in continue biotheles)	If Under 1 Year	gerstow			Birthplace (State or Foreign
	Funeral Director			M 2 X F 7. Age (	(In yrs. last birthday) 68 Yrs.	Months Days		Min. 8. Date of Bird (Month, Da Sept	7 1937	Country) Pennsylvania
			Usual Residence of Decedent					Вере	, 1337	
	ylanc how		10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	e Ma	Director	Maryland Washingt	con	Hager					X Yes 2 No
	ith th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
	s 23a	ral	109 East Hillcre	st Rd.  2. Was Decedent Ev		Mas Decadest of h	21742	2 (Specify Ves or No		d States
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "neturel", or Items 23s or 28s-f show any injury or other treumatic event. The Modical Execution matter resulted at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 🎇 No	an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)		white etc.
9	2 hou	ted	15. Decedent's Educ	ation		dent's Usual Occu		f dein -	16b. Kind of Bus	siness/Industry
215	hin 72 an "ne Maril	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of d)	working		
2	ad with	Som	12			retary				ction Co.
n	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		))
<u>Y</u> a	ould Men varke	မ	Otto Gras		101 11 11			resa Mille		24-1- 72- O-d-1
Maryland 21215-0036	12 sh h and 7 is m treum		19a. Informant's Name/Relationship (Typ					or Rural Route Number		state, Zip Codej
	1 and Healt em 2	1	Laurie A. Pentis 20a. Method of Disposition	(daugnter	20b. Place of Dispo	N. 76th	!	Date Date	8114 20c. Location - 0	City or Town, State
JO I	ages ant of tt: If It		1 ■ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State		matory or other pla	!	11 26 05		
Baltimore,	nit. Partme orten injur	ì	21. Signature of Funeral Service License	e 7		en Cemet  Name and Addre	ery ess of Facility			wn Maryland Funeral Home
ñ	Department Department		(1) mucho A	Ting	13	31 Easte	rn Blvd			aryland 21742
	**		23a. Part1. Enter the disease or complice shock, or hear failure. List only on	cations that caused to	he death. Do not ent					Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition		clerotic (	Coronary	Artery	Disease		Onset and Death
	/Medical Examiner		resulting in death)		consequence of):	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		DADGGG		
	Lxammer	L	Sequentially list conditions, if any, leading to immediate		connection of					
	ed sit	Jule	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
6	xecul and	Examiner	that initiated events cresulting in death) Last	Due to (or as a	consequence of):					
760,	te be executed ysician and te burial-transit	calE	d							
89	ificate g phy as the									
Вох	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	y		23d. Date Mon	of delivery th Day Year
O.		hys	9 Unknown	9□ Unknown						
s, P	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause gi	ven in Part I.	**		bute to the cause of death?
ord	v require been sig should b								Yes 2∐No :	3 Probably 4 Unknown
Record	e law r has be ge 2 sh	ple						24a. Was	osy pr	ere autopsy findings available rior to completion of cause of
= =	Th ate pag	Completed						1 ☐ Yes		eath? □Yes 2□No
Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:		0:	hor	Death (Check only o		
o	Phys this ral dir	₽:	1 No 2 No 2 No 27. Manner of Death	1 🗀 Inpatien		nt 3 DOA	4   Nursi	ng Home SCResi	dence 6 Othe now injury occurre	
	ding I h. After funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day	Year) Injury	of 28c. Inju Wo M 1	rk? ]Yes 2∐No			
Division	Attending r death.	flca	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, str	reet, factory, office	1111	28f. Location (		r or Rural Route Number,
ā	s afte	Certification:	4 Homicide	building, etc.	(Зреспу)			City of 700	wii, Siaiby	
	To the Hospitel or Attendi wilhin 24 hours after death. To the Funeral Director: A completely filled in by the fo	edical	29a. Certifier   1 Certifying Phys (Check only one)	sicien: To the best of er: On the basis of e and manner state	examination and/or in	h occurred at the to vestigation, in my	ime, date and popinion, death	place, and due to the occurred at the time,	cause(s) and man date and place, a	nner as stated. nd due to the cause(s)
	To the To the Comp	×	29b. Signature and title of Certifier	11.1		29c. Licen	se number		29d. Date signed	(Month, Day, Year)
)			> / House	Kelker		D001	1266		November	22, 2005
1	9H-10		30. Name and address of person who co Howard N. Weeks,	MD 580 No	ath (Item 23a) (Type, orthern Av		stown.	MD 21742		
Ĩ		ate rar	31. Date filed (Month, Day, Year) NOV 2 3 20	32. Registrar	's Signature					
Q.		2001			1					

ORIGINAL

		•	For State Registrar	State of Mar		tificate of l			og. No.	39172					
			Decedent's Name (First, Middle, Last)					2. Date of Death	h Day Yea	3. Time of Death					
	Physicia /Medic		Henry J. Johnson	, Jr.					r 14, 200						
	Examin		4a. Facility Name (If not institution, give st	h	4c. County of D	eath									
			Suburban Hospital			Bethese			Montgo						
	Funeral Director		5. Social Security Number 6. Sex 578-09-8270 光口	7. Age (i	In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Year) 9. 9 1920 W.	Birthplace (State or Foreign Country) ashington, DC					
	pug 🔉		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits					
	Maryle f sho	٥	Maryland Montgom		Kensingt					1 X Yes 2 ☐ No					
	the t	Director	10e. Street and Number	ery	Rensingt	10f. Zip Code		10	0g. Citizen of What	Country?					
	3a or		3504 Stark Street			20895			US	A					
	ns 2;	Funeral	11. Marital Status	2. Was Decedent Eve	er in U.S. 13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No-	14. Race - A	merican Indian,					
36	be filed within 72 hours after death with the Maryland tial Hygiene. Id other than "naturel", or Items 23e or 28e-f show event, the Medical Examinar ribal be notified at	by Fur	1 ☐ Never Married 2 1 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 9		lYes, specify Cuba 1□Yes 2⊠No	Specify:	to Hican, etc.)	Black, W Specify: W						
Maryland 21215-0036	72 hou	ted	15. Decedent's Educ			dent's Usual Occup		urking	16b. Kind of Busine	ss/Industry					
218	within 7 ene. than "n	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)								
21	e filed within al Hygiene. other then '	S		5+	Mechar	ical Syster				es Government					
Pug.	be fill Hall Hall Hall Hall Hall Hall Hall H	Be	17. Father's Name (First, Middle, Last) Henry J. Johnson,	Sr				me (First, Middle, A Teresa Co							
ž	should be tand Mental I	٦ و	19a. Informant's Name/Relationship (Typ		19h Maili	ng Address (Street		ural Route Number,		a. Zip Code)					
Ma	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 ie marked any injury or other traumetic e QDCB.		Dolores M. Johnson					nsington,		A A					
ō,			20a. Method of Disposition	,	20b. Place of Dispo	sition (Name of	. 1	Date	20c. Location - City						
ē			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5X☐ Other (Specify)	emoval from State Entombment	-	natory`or other plac Jeaven Cemet	11000	mber 22, 005 S	Silver Sp	ring, Maryland					
Baltimore,	permit. I Departm Importar any injur		Francis Signature of Funeral Service Licensee,  Francis Scotting Funeral Home Inc  Scotting Blvd, W, Silver Spring, MD 20901												
			23a. Part1. Enter the disease, or complic	ations that caused th	ne death. Do not en					Approximate					
	Physician		shock, or heart failure. List only on Immediate Cause (Final			10:1	DTED	1, 7,	CENCE	Interval Between Onset and Death					
	/Medical		disease or condition resulting in death)	Due to (or as a	OLOW)	1/4	RIER	y De	307136						
	Examiner		Sequentially list conditions		_	MONI									
	D **	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
	acute and trans	Examiner	Cause (Disease or injury that initiated events c. resulting in death) Last	1SCH	EMIA										
8760,	icate be executed physician and s the burial-transit	Ē	resulting in death, cast	Due to (or as a o	consequence of):										
87	physics the t	dical	d												
Вох 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Me	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of Month	delivery Day Year					
o.	by the drached	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	no or dou		200000000								
<u>α</u>	res that igned b be deta	þ	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?  Probably 4 □Unknown					
o	w require been si should	eted						-							
I Records,		Completed						24a. Was a autops perform	y prior						
Vital	Physician: The this certificate ral director, pag	Be (	25. Was case referred to medical examiner?					eath (Check only on	e)						
of \	hysic this co	2	1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient			4 🗆 Hursing	Home 5 ☐ Reside		Specify)					
Ē			27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wor		28d. Describe ho	ow injury occurred						
Sio	Attending r death.	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Disease (Injury	. At home laws		Yes 2 □ No	281 Location (St	reet and Number of	Rural Route Number,					
Division	after of Direct	Certification:	4 Homicide determined	building, etc.	y - At home, larm, st (Specify)	reet, ractory, onice		City or Town	n, State)	ridia ridule rumber,					
				icien: To the best of											
	To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Examination)	ner: On the basis of e and manner state		ivestigation, in my o	pinion, death occ	curred at the time, d	ate and place, and	due to the cause(s)					
	To th To th comp	Me	29b. Signature and title of certifier	>		29c. Licens			9d. Date signed (M	•					
),	5+1		•	mala	er, ur	DOC	571.	24	11/14/0	20					
1	2.1		30. Name and address of person who co Truong Bao, M.D.	mpleted cause of dea	ath (Item 23a) (Type ecutive P	Print)									
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NÖV 1 7 200	32/Registrar	MOV 1 by 200E I & A A A A A A A A A A A A A A A A A A										

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Schnson Henry

		. For	State of N			irtment of			•	_	15	391	73	
		1 - State Registrar			Cer	tificate of	f Death		Reg	. No.			, 0	
Physici	an	1. Decedent's Name (First, Middle, Las	t)					2.	Date of Death Month	Day	Year	3. Time of D	eath	
/Medic			(eys						ovember	7	2005	0605	М	
Examir	er	4a. Facility Name (If not institution, give				4b. City, Town,		Death	i	4c. County of Death				
		Anne Arundel Me  5. Social Security Number 6. Se			la at histhelau)	Annapo		A Hrs o	Date of Birth	Anne Arundel				
Funeral Director		577-22-8936	X 2□ F /	84	last birthday). Yrs.	Months Day		Min. J	Date of Birth (Month, Day, Y une 12,	1921	Wash:	ace (State or I iny) ington,	DC	
pu .		Usuel Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					11	d. Inside City	Limite	
laryla eho	ក		1 - 1								'	1 ☐ Yes 2		
16 N	Director	MD Anne Aru	mder	Ed	gewate	10f. Zip Code			100	. Citizen of	What Coun		Λ	
was after death with the Marylan elf, or teme 23s or 28s-f ehow Exercises must be mutified at	흐	1200 Dixona Drive	3			210			109	USA	vviiat Oodii	oy:		
leath	Funeral	11. Marital Slatus	12. Was Decede	nt Ever in U.	S. 13. V	Vas Decedent of Yes, specify Cu		in? (Specif	v Yes or No-		e - America	an Indian.		
ifter of the second	T I	1 ☐ Never Married XXMarried	Armed Force 1 ☐ Yes 2 If Yes, Give	s? ∐No				Puerto Rio	an, etc.)	Blac	ck, White, e	etc.		
ours a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date:	s:		☐Yes 2XXV	o Specify:			Specify	y: Wh:	lte		
be filed within 72 hours after death with the Maryland filed within 72 hours after death with the Maryland of other then "naturel", or iteme 23a or 28a-f ehow do other then "naturel", or iteme 23a or 28a-f ehow event, the Madical Exercit at most be notified at	Completed	15. Decedent's Ed (Specify only highest grad			(Give	lent's Usual Occ kind of work don OO NOT use retii	e durina most o	of working	16	b. Kind of B	usiness/Ind	ustry		
Athin 19	Elementary/Secondary (0-12)	_	.1£ E-	1	٦									
lled v tygie her ti		17. Father's Name (First, Middle, Last)	de Namo (F	First, Middle, Ma	elf-En		:a							
2 should be filed within and Mental Hygiene. Is marked other then eumatic event, the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Men	å	Whitney Samuel Ke	,	McDonou		ne)								
d Me	ဥ	19a, Informant's Name/Relationship (7	State, Zip	Codel										
Dermit. Pages 1 and 2 should by Dermit. Pages 1 and 2 should by Department of Health and Mental Important: If tem 27 is marked any injury or other treumatic engage.		Hazel Bell Keys	· · · · · · · · · · · · · · · · · · ·			St. Mar				-				
Hear Hear		20a. Method of Disposition			lace of Dispo	sition (Name of	Ţ	Date	-	c. Location -				
Pages ent of nt: #1		1 Burial 2XXCremation 3 4 Donation 5 Other (Specify		10	-	natory`or other pi ematory		1/11/	2005 B	altimo	ore. N	(ID		
mit. I sartm sourts		21. Signature of Funeral Service Licen		110		Name and Add	ress of Facility	222-55	- 64-07		,, _			
2 5 5 5 8		Dall A	Sh			Hardest	y Fune: zelv Ave	ral H	ome, P. Annapo	A. lis. N	D 214	101		
THE ST		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	espiratory arrest		1000	Approximate Interval Betwe	en							
Physician	U	Immediate Cause (Final disease or condition	0	1		Inout	_					Onset and De		
/Medical		resulting in death)	Due to (or	as a conseq	uence of):									
Examiner		Sequentially list conditions.	b. /	espi	roto	ug &	rest							
be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events  c.												
and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):	dan	of a	nce	1					
te be executed ysicien and he burial-transit	cal E		_			(								
John Contilicate Leath certificate I			d											
onding use a	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			le .				23d. Da	le of delive	у		
death death of for	Physician/Medi	in the past 12 months? 1 Yes 2 No	1 Live birth	at time of d		Ectopic pregnan   Other <i>(specify)</i>	icy			Mo	onth	Day Yea	ar	
thet the de	hys	9 Unknown	9□ Unknowr											
0 % 5 0	by	Part II. Other significant conditions of	entributing to death	but not res	ulting in the ur	nderlying cause o	given in Part I.		23e. Did toba					
w require		_ recurer	1 Peer	nas	THE	icion			1 🗆 Yes	2 🗆 No	3 Proba	ibly 4 🖫 Thi	KNOWII	
e law r	Completed	Coronory	Site	eng	175	ease			24a. Was an autopsy	24b.	Were autop	sy findings av	ailable ise of	
ysicion: The l is certificate he director, page	S			0					performe 1 ☐ Yes 2 ☑	0?	death? 1 🔲 Yes			
vicion: Th icion: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:					of Death (C	Check only one)					
at this dir	ို	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 _ Inpa		ER/Outpatien 28b. Time of	3 DOA			5 Residence  1. Describe how			)		
After Funding	Fig	1 ☑Natural 5 ☐ Pending	(Month, i	Day Year)	Injury	28c, Inj W	ork? □Yes 2□N		. Describe now	milary occur	180			
Atten deat ctor: y the	fica	3 Suicide 6 Could not be		Injury - At ho	ome, farm, str	eet, factory, office			. Location (Stree	et and Numb	er or Rural	Route Numbe	er.	
d in th	Certification:	4 Homicide	building,	etc. (Specifi	y)	,			City or Town, S	State)				
pepita hours unere y fille		29a. Certifier 1 Certifying Ph	ysician: To the be	st of my kno	wledge, death	occurred at the	lime, date and	place, and	due to the caus	se(s) and ma	anner as sta	ited.		
To the Hospital or Attending Physicien: To the Hospital or Attending Physicien: To the Funerel Director: After this certification of the Funerel Director.  To the Funerel Director or After the Completely filled in by the funeral director,	edicai	(Check only 2 Medical Examone)	and manner	stated.	tion and/or inv	estigation, in my	opinion, death	n occurred	at the time, date	and place,	and due to	the cause(s)		
Tot To t	Σ	29b. Signature and title of certifier	0 /			29c. Lice	nse number		29d	Date signe	d (Month, L	Day, Year)		
		Deluto	od. Ka	uno	L, and	D41	1034		No	whole	, 7	2005		
		Califord 1	completed cause of								220		,	
		Salvatore LAU  31. Date filed (Month, Day, Year)	RIA 12	S LVIB strar's Signa	RANO	DRIVE	SUITES	500	ANNAPO	45,	MID	21401	/	
Sta Registi		MY 1 6 20	05 January	otiais signa	K A	and a		-		•				
		20 a - 50	- J-60	100										

HAROLD A. KASS 05-07956 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

		1- State Unpend Item . Registrar		- Ce	ertificate	of L	Death		Reg. No		39174			
Physicia	an	1. Decedent's Name (First, Middle, Last			77			2. Date of D Month	Da	y_ Year	3. Time of Death			
/Medic	al	Harold  4a. Facility Name (If not institution, give	A.		Kass			NOVEM		25, 2005	3:30P. M			
Examin	er	875 COACHWAY			ANNA	POL:			Aì	NE ARUN				
Funeral Director		5. Social Security Number  065-22-9118  Usual Residence of Decedent	x 7. Ag ZM 2□F	e (In yrs. last birthda 74 Yrs.		Year Days	If Under 24 H Hours Mi		ay, Year)	9. Birth Cou New	place (State or Foreign ntry) York			
yland		10a. State 10b. County		10c. City, Town or	ocation						10d. Inside City Limits			
a-fer	ctor	MD Anne Aru	ındel	Annapo	lis						1 ☐ Yes 2 🛣 No			
or 28	Olre	10e. Street and Number			10f. Zip C	ode			10g. Cit	izen of What Cou	ntry?			
sath w	sral	875 Coachway	10 144 0	E 110		2140		10 11 11		USA				
Nore, Maryland 21215-UU36  ges 1 and 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evant er must be redified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔯 I If Yes, Give Year or Dates:	Ever in U.S. 13	. Was Decede If Yes, specif 1 ☐ Yes 2			(Specify Yes or N erto Rican, etc.)	0-	14. Race - Ameri Black, White, Specify: Wh				
21215-0036 of within 72 hours aff giene. or than "natural, or the Medical Every	Completed	15. Decedent's Edu (Specify only highest grad	cation	16a. Dec	edent's Usual	Occupa	tion	and in a	16b. K	ind of Business/In	dustry			
within within one.	nple	Elementary/Secondary (0-12)	College (1-4or 5	o+)		retired)	uring most of w	rorking						
filed w Hygier ther ti		17. Father's Name (First, Middle, Last)	4	Phys	icist		19 Mothoda N	ame (First, Middle			Engineerir			
and de final head of certain	o Be	Louis Kass								,				
Maryland of 2 should be file the and Mental Hy 27 is marked oth traumatic event	입	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Ma	ling Address (	Street a		nce Rothe			Code)			
and 2 aalth a n 27 is er trau		Gullan C. Kass (W	(ife)					olis, MD			,			
ore, M es 1 and 2 of Health litem 27 i		20a. Method of Disposition		20b. Place of Disp		of		Date		cation - City or To	own, State			
Page Page ment of ury or		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State		•	•	1	28-2005	Ba1	timore,	MD			
Baltimore, permit. Pages 1 a Department of Hee important: If Item ony injury or othe		4 Donation 5 Other (Specify) Metro Crematory 11-28-2005 Baltimo  21. Signature of Funeral Service 1 Crematory 22, Name and Address of Facility Hardesty Funeral Home, P.A.  12 Ridgely Avenue, Annapolis, MD  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.												
I CO Ite be iysicia of bur	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as	hene and a a consequence of): a consequence of):	cetami	nopł	nen into	oxication	1		Onset and Death			
hat the death certific that the death certific ed by the attending p detached for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic preg □ Other (spec					23d. Date of delive Month	ery Day Year			
uires that		Part II. Other significant conditions cor	ntributing to death bu	ut not resulting in the	underlying cau	se give	n in Part I.		tobacco u Yes 2[		ne cause of death?			
of Vital Records, hysician: The law requires the certificate has been signed ifficated to should be	e Completed	25. Was case referred to medical					26 Place of D		psy prmed? 2 No	prior to con	psy findings available mpletion of cause of 2 No			
ysici	T0 B	examiner? 1 XYes 2 □ No	lospital: 1   Inpatie	nt 2 ER/Outpatie		Other	4 Nursing	Home 5 ☐ Resi		S Other (Specifi	SCENE			
After fune	atlon;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur Found: Day 11-25-0	/ rear) Injury	of <b>unk</b> 286	Work'	at	28d. Describe	how injur					
DIVISION  To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc.  Home	ury - At home, farm, s c. (Specify)	treet, factory, o	office	28f. Location (Stree City or Town, S Annapolis			Number of Rura 1875 Coac MD	Route Number, <b>hway</b> ,			
To the Hospital within 24 hours e To the Funeral I completely filled	Medical	29a. Certifier (Check only one)  1 Cartifying Physical Examination (Check only one)	sician: To the best on nar: On the basis of and manner sta	of my knowledge, dea examination and/or i ited.	th occurred at nvestigation, in	the time my opi	e, date and place nion, death occ	ce, and due to the curred at the time,	cause(s) date and	and manner as st place, and due to	ated. the cause(s)			
To T Com	2	29b. Signature and title of certifier	w				number M.E.	N		BER 26,2				
		30. None and address of person who co	mpleted cause of de	eath (Item 23a) (Type		PENN	STREET	BALTIMO	RE,M	ARYLAND	21201			
		31. Date filed (Month, Qay, Year)												

DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Man	yland /		artment o			nd Me	ental H	/gie	_ U U	5	3917	5
	Discontinu		1. Decedent's Name (First, Middle,	Last)								2. Date of D	eath	Day	V	3. Time of D	Death
	Physici /Medio		Anthony	Joseph		Koni	eczny	7				NOV.			Yeer	4:55A	М
	Examin		4a. Fecility Name (If not institution,	AL CONTRACTOR OF				4b. City, Tow	n, or Lo	cation of	Death			4c. County	of Death	1	
			SALISBURY REHAB					SALISBU							MTCO		
	Funeral Director			6. Sex 1⊠M 2□F	7. Age (I	n yrs. last i	Yrs.	Months Da		Hours	Min.						Foreign
			214-10-6679 Usuel Residence of Decedent									10/29,	120	07	new .	TOLK	
	anyland ahow		10a. State 10b. County		10	Oc. City, To	wn or Lo	cation								10d. Inside City	Limits
	the Mar 28e-f at notified	ţċ	Maryland Wico	omico		Sal	isbu	су								X∏Yes 2	2 🗌 No
	ith the Maryla or 28e-f ahor be notified at	Director	10e. Street and Number					10f. Zip Cod	ie				10g.	Citizen of	What Cou	intry?	
	hours after deeth with the Maryland tural', or Items 23a or 28e-f ahow al Exercitiver must be notified at		1514 Riversid	le Dr., A	pt. C	2224		2	180	1				USA			
	er de	Funerai	11. Marital Status	Armed Fo	rces?	dent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp. 15 f Yes, specify Cuban, Mexican, Puerto					n? (Spec Puerto R	ify Yes or N ican, etc.)	0-		ce - Ameri ck, White	ican Indian, , etc.	
36	s aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 □Yes If Yes, Giv Year or D	2 ☐No 1 ☐ Yes 24 ☐ No Specify:									Specif	y: W	hite	
윽	turs a	ed	15. Decedent's		16a. Decedent's Usual Occupation							16h	Kind of B				
215	n 72 n "nai	Completed	(Specify only highest	grade completed)	. Ans E . )	(Give kind of work done during most of wo					f working	orking 16b. Kind of Busi			03111033/11	loustry	
21,	d with	ĕ	Elementary/Secondary (0-12)	College (1	1-401 5+)		Part	s Depa	rtme	ent M	lanaç	jer		moti	ve		
≥ P	be filed with that Hyglene of other the event, the	Be	17. Father's Name (First, Middle, L	-					18			First, Middle			ne)		
S S	ould by Ment	2	Anthony Joseph		ny Sr	•				Apol	ovia Mleczek						
ANTHONY , Maryland 21215-0036	iges 1 and 2 should be filed vin of Heelth and Mental Hygles it if item 27 is marked other? or other traumatic event, it	4	19a. Informant's Name/Relationshi		c .			g Address (Str						-			
A. 6.	is 1 and of Heelth Item 27 other to		Thelma M. Koni	eczny/wii				Rivers	_	Dr.,		2					
TECZNY, B	in it of the or of or of		20a. Method of Disposition 1 ☐ABurial 2 ☐ Cremation					sition (Name of latory or other)		1 3 -	Da			Location -			
I i	it. Parturent		`4 □ Donation 5 □ Other (Sp.		,	Parso		emetery			1/16		_	alisb	-		
KONLECZNY,  Baltimor	permit. Pages Depertment of Importent: If it any injury or o		21. Signature of Funeral Service U	Gon	בכני	CFS	P	HOTTOWS 501 Snc	ysf w H	unera ill I	al H Rd.,	ome Pr Salis	ofe	ession Cy, M	nal <i>l</i> D 218	Associat 304	tion
	Physician /Medical printing the printing transit	I Examiner	23a. Part1. Enter the disease, or content shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	or as a co	onsequence onsequence	e of):	feng / Lei	2	) es e					9	Approximate Interval Betwee Onset and De	en ath
P.O. Box 68760,	requires thet the death certificate be ex seen signed by the attending physicien hould be delached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregn 9☐Unkno	inth 2. ☐ aunt at time own	Fetal death	5 🗆	Ectopic pregna Other (specify)						23d. Dat Mo	e of delive	ery Day Yea	ar
ds, l	thires the signed id be de	Ď	Part II. Other significant condition	s contributing to de	eath but no	ot resulting	in the un	derlying cause	given ir	n Part I.						ne cause of dea pably 4 🖯 Unk	
Division of Vital Records,	aw 1st	e Completed	OF Wassers should be suffered									1 ☐ Yes	psy rmed? 2	' _ (	Were auto prior to con leath?	psy findings ava mpletion of cause 2 No	ailable se of
₹	Physician: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2  No	Hospital:	nnationt	2∏ER/C	lutantiont	3□ DOA				Check on o		2 <b></b>			-
on of	ding Phy n. After this funeral d	-	27. Manner of Death  1 Natural 5 Pending	28a Date of			Time of Injury	28c. In	ijury at Vork?	2   No	28	d. Describe				Y)	
Divisio	To the Hospital or Attending Physician: The i within 24 hours after death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	ot be 28e. Place	of Injury - ng, etc. (S	At home, i	farm, stre	et, lactory, offic		2 ( ) 140		f. Location ( City or To	Street a	and Numbe	er or Rura	l Route Numbe	r,
J	To the Hospital within 24 hours e To the Funeral I completely filled		(Check only 2   Medical E	Physician: To the kaminer: On the ba	best of m	y knowledg	ge, death	occurred at the	time, c	date and p	lace, and	d due to the	cause	(s) and ma	nner as st	ated.	
	the I the I mplet	Medical	oney	and mann	er stated.			29c. Lice									
	S ± S S	-	29b. Signature and title of certifier	1//				ZSC. LICE	niae iiu	p 7	1	2	29U. L	ate signed	(MORITA, I	way, rear)	
	, ,		1/1/1/	1-				2	2	12	× ]		L	119	105		
	Comt		30. Name and address of person w			-		•	DΨ	MIX	7 77 6	004	,	e e			
	Sta	te	31. Date filed (Month, Pay, Year)	32. FH	gistrar's		3 . / .	WITOBU	KI,	IID•	218	004					-
	Registra		NUV 16	2005	MUR	, H.	A	and of									

ORIGINAL

Examiner death certificate be executed P.O. Division of Vital 0 Hospitei

Baltimore, Maryland 21215-0036

been signed by the should be detached page 2 certificate After this certifice funeral director, r s efter death. illed in by within 24 hours e To the Funeral I The C 0

10+1

DHMH 17 Rev 1/2001

State Registrar (Check only

29b. Signature and title of certifier

Ispisc 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registras Signature 2005

Glower

29c. License number

026358

29d. Date signed (Month, Day, Year)

NOV-25,2005

		ľ	For State Registrar		f Maryland	/ Depa		t of H	ealth a	and Me	ntal Hygie	_	05	39177
1	Physicia /Medic		1. Decedent's Name (First, Middle Mildred Arlen	ne King						٨	Date of Death Month OVEMBE	Pay 20		
	Examin	er	4a. Facility Name (If not institution	-					Location o				nty of Death	
		ă-	Washington Cou	INTY HOSPI	7. Age (In yrs. last	birthday)	If Under		rstow If Under		. Date of Birth			on County
	Funeral Director		215-20-8700 Usual Residence of Decedent	1□M 2 <b>X</b> F	78	Yrs.	Months	Days	Hours	Min.	Date of Birth (Month, Day, Yarch 6	ear) 1927		nplace (State or Foreign untry) yland
	yland		10a. State 10b. County		10c. City, T									10d. Inside City Limits
	death with the Maryland ims 23a or 28a-f ehow r must be notified at	Funeral Director		shington	Н	ager	stown	Code			100	Citions	4 14/hat Car	1 ☐ Yes 2 No
	with ti	급	10e. Street and Number				10f. Zip		740		109		of What Cou	undyr
	eath	eral	12918 Cathedr	12. Was Dec	edent Ever in U.S.	13.	Was Deced		742 spanic Ori	igin? (Specif	fy Yes or No- can, etc.)		S.A. ace · Amer	ncan Indian,
	after or its	by Fun	1 Never Married 2 Mar 3 Widowed 4 Divorced	ned 1 ☐ Yes	orces? Ž <b>X</b> ⊤No		If Yes, spec 1 ☐ Yes		n, Mexicar Specify:		ćan, etc.)		lack, White cify: <b>Wh</b>	
21215-0036	d within 72 hours jiene. r than "naturel", the Medical Exe	Completed	15. Deceder (Specify only highe	nt's Education st grade completed)	1	6a. Dece	dent's Usua kind of wo	l Occupa	ation <i>Juring</i> mos	at of working	16	b. Kind of	Business/l	ndustry
121		dmc	Elementary/Secondary (0-12)	College (	1-4or 5+)		Homem		,			Po	reona	l Residence
d 2	filed withir I Hyglene. other than	Be Co	17. Father's Name (First, Middle,	Last)			TOTICIL	INCL	18. Mothe	er's Name (F	First, Middle, Ma			T RESTUENCE
Maryland	ges 1 and 2 should be filed t of Heelth and Mental Hyg If Item 27 is marked othe or other traumatic event,	ToB	Walter W. Ya	ites							Slye Ya			
Man	12 sho		19a. Informant's Name/Relations William E. Kin				•				Route Number, C erstown	-		
ຄົ	ss 1 and 3 of Heelth Item 27 r other tr		20a. Method of Disposition	ig 01. (IIu	20b. Place	e of Dispo	sition (Nari	ne of		Date				Fown, State
E O	permit, Peges Depertment of Important: If It any injury or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		en Cei		1	11-23	-05 I	lager	stown	Maryland
Baltimore,			21. Signature of Funeral Service	Licensee	ine	22	2. Name an	d Addres	s of Facilit	b Doug	las A.Fi	iery :	Funer	al Home yland 21742
	Physician /Medical Examiner		23a. Part1. Enter the disease, o shock, or heart allure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	aDue to	or as a consequent	04.047 ce of):	allu-	/3	g, such as	3	espiratory arrest			Approximate Interval Between Onset and Death
68760,	icate be executed physiclen and s the buriat-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last	C. Due to	Cor as a consequent of as a consequent of the co	ailur	e L Au	eur	755	Repu				
P.O. Box (	The law requires that the death certificate I te has been signed by the ettending physi tage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 SPNo 9 ☐ Unknown	as decedent pregnant the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)  Another (specify)							Date of deliment	very Day Year		
	uires that signed b ld be deta	þ	Part II. Other significant conditi	ons contributing to d	leath but not resultin	ng in the u	nderlying c	ause give	en in Part I					the cause of death?
Division of Vital Records,	elcian: The law requira certificate has been si- irector, page 2 should b	Completed								_	24a. Was an autopsy performe	d?	prior to c death?	topsy findings available ompletion of cause of
ta		0	25. Was case referred to medica	al					26. Place	e of Death (	Check only one)			
>	yelclan: IIS certific director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2□ER	/Outpatier	nt 3 DC	A Othe	9F. 4 □ NL	ursing Home	5 Residence	e 6 □0	ther (Spec	ufy)
0	ding Phy After thi funeral	:uo	27. Manner of Death 1 ☑ Natural 5 ☑ Pendi	28a. Date (Mor	of Injury 28 oth, Day Year)	b. Time o Injury		8c. Injury Work			d. Describe how	injury occ	urred	
ivisio	or Attending Phyelclen: after deeth. Director: After this certifica in by the funeral director, i	Certification:	2 Accident invest 3 Suicide 6 Could 4 Homicide determ	e of Injury - At home ling, etc. (Specify)	M reet, factory		Yes 2□		f. Location (Stree City or Town,	et and Nur State)	nber or Ru	ral Route Number,		
Ω	To the Hospital or Attend within 24 hours after deeth To the Funerel Director: / completely filled in by the fi		(Check only 2 Medical	ng Physician: To the Examiner: On the b	pasis of examination	dge, deat and/or in	h occurred	at the tim	ne, date an pinion, dea	nd place, and	d due to the cau at the time, date	se(s) and r	manner as e, and due	stated. to the cause(s)
	To the P within 24 To the F complete	Medical	one) 29b. Signature and title of certific	and mar	nner stated.				number					n, Day, Year)
	T W I		72 - C					1)	582	67		11.2	21-1	<u></u>
			30. Name and address of person	who completed cau	se of death (Item 23	Ва) (Туре,	Print)		J 1	, — /		. 1		
5/4	1-9		D. W. S	L- 1111	0 Nedu	cel	Can	pur	Ro	1	1479.1	nd		
4	Sta Registi		31. Date filed (Month, Day, Year NOV 2	3 2005	Registrar's Signature	9.	Jane de	j.			t			
DH	MH 17 Rev 1/2	1,000	101		CALL SALVES	17								

			For State of Registrar	Maryland / Dep <i>Ce</i>	artment of He rtificate of D	eath	Rag.	400J	39178			
	o Physicia		1. Decedent's Name (First, Middle, Last)		** 1	Me	te of Death onth	Day Year	3. Time of Death			
	/Medic	al .	Lucille Elizab		Knode  4b. City, Town, or L		ember	18, 2005 4c. County of Death	12:33 P <sup>M</sup>			
1	Examin	er	4a. Facility Name (If not institution, give street and num 213 <b>High St</b> .	ib <del>a</del> r)	Hagerst			Washingt				
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs. 8, Da	te of Birth					
	Director		215-26-1956 <sup>1□ M 2</sup> The state of the stat	78 Yrs.	Months Days		4,19					
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits			
	Aaryla f aho	0		Hagerst					1 ☑ Yes 2 ☐ No			
	28a-	rect	Maryland   Washington	Hagerse	10f. Zip Code		10g	. Citizen of What Cou	intry?			
	3a or		213 High Street		21740			USA				
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. then the marked other then "natural", or Itams 23s or 28s-1 show itam 27 is marked other then "natural", or Itams 23s or 28s-1 show other traumatic event, the Madical Examination at the mailied at	by Funeral Director		2 <b>X</b> No	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2 🔀 No	panic Origin? (Specify Y , Mexican, Puerto Rican, Specify:	es or No- etc.)	14. Race - American Indian, Black, White, etc. Specify: White				
21215-0036	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	edent's Usual Occupat	ion Iring most of working	16	b. Kind of Business/Ir	ndustry			
21	e filed within 7 al Hygiene. I othar than "r vant, the Mate	Completed	Elementary/Secondary (0-12) College (1	-4or 5+)	e kind of work done du DO NOT use retired)			D				
2			17. Father's Name (First, Middle, Last)	Home	maker	18. Mother's Name (First	. Middle, Ma	Domestic				
anc	ould be fi Mental H sarked ot atic eval	) Be	John H. Knode			Lucille J						
Maryland	2 should I and Meni Is marker raumatic	Ţ.	19a. Informant's Name/Relationship (Type, Print)	19b. Mail	ing Address (Street an	nd Number or Rural Rout			ip Code)			
	and 2 ealth a m 27 Is		Harry W. Knode/Son	335	Liganore A	venue, Hage	rstown	n, Md. 217	40			
ře,	os 1 and 2 of Health of itam 27 l		20a. Method of Disposition 1 ☑ Burial 2 □ Cremation 3 □ Removal from 9	20b. Place of Disp cemetery, cre	osition (Name of ematory or other place,	Date	20	c. Location - City or T	own, State			
<u>iii</u>	nit. Page bartment o ortant: II injury or		'4 □Donation 5 □ Other (Specify)	Rest Hav	en Cemeter	-			, Maryland			
Baltimore,	permit. Pages Department of I Important: If its any injury or of		21. Signature of Funeral Service Licensee		apel Md. 21742							
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on e	avised the death. Do not er	nter the mode of dying	, such as cardiac or resp	iratory arrest	t,	Approximate Interval Between Onset and Death			
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Box (	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant 1 Live b	ant at time of death 5	□Ectopic pregnancy □ Other (specify)			23d. Date of delik Month	very Day Year			
, P.O.	ires that t signed by d be detad	by Ph	Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause giver	n in Part I. 2	3e. Did tobac	cco use contribute to	the cause of death?			
rds	quires n sign uld be	d be	CAROBAOVASCUNA ACCIDE				1 🗆 Yes	2 □ No 3 □ ro	bably 4 Unknown			
of Vital Records,	he law requii e has been s ige 2 should	Completed	MYCHRIONSON DURKKS	STON, CHOCK	nie ors		4a. Was an autopsy performe □ Yes 2 1	prior to c	opsy findings available ompletion of cause of			
tal	ician: Th certificate ector, pag	a)	25. Was case referred to medical			26. Place of Death (Che		110				
Į V	Phyaici this cer al direc	To B	examiner? 1 Yes 2 Hospital: 1 1	npatient 2 ER/Outpatie		4   Nursing Home	Residence	ce 6 □Other (Spec	ify)			
	Jing Ph n. After th funeral		27. Manner of Death  Natural 5 □ Pending  28a. Date (Moni	of Injury th, Day Year) 28b. Time Injury	Work		escribe how	injury occurred				
Sio	eath. or: A	catio	2 Accident investigation			es 2 No	nation (Ctm	at and Number or Pu	m I Pouto Number			
Division	after d Diract Diract	Certification;	determined 200. Flace	of Injury - At home, farm, s ng, etc. (Specify)	treet, factory, office	201. C	ity or Town, S	et and Number or Rui State)	al Houle Number,			
	To the Hospital or Attending Physician: The within 24 hours after death. To tha Funaral Diractor: After this certificate his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  Cartifying Physician: To the band manipulation of the part of the par	best of my knowledge, dea asis of examination and/or i ner stated.	ath occurred at the time	e, date and place, and du inion, death occurred at t	ue to the caus the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)			
	within To the compl	Me	29b. Signature and title of certifier		29c. License			. Date signed (Month				
			BRNEST UZICANIN	1-m0	0466	,22	101	10021, 2	005			
	=		30. Name and address of person who completed cause	se of death (Item 23a) (Type	e, Print)	1/0	naa.	a Aread	14.0			
			BYCV BY UN CANIV - MI 31. Date filed (Month, Day, Year) 326	17056 IV	BADOW V	16W DK 1	1466	KSYMIN	10/1			
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# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryla		artment of F <i>tificate of</i>			ene Like 00	5	39179				
	Physici	an	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day	Voor	3. Time of Death				
	/Medic		Sharon Carletta Ledford				November	20, 2	2005	7:30 PM				
	Examir		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or Lo	ocation of Death	4c. County	of Death					
			449 Clarendon Avenue			Hagerstov		Washi	ngtor	1				
В,	Funeral		1 M 2 M E	rs. last birthday)	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	(ear)	9. Birthpl	ace (State or Foreign				
	Director		231-80-2622 52	2 Yrs.			April 24	1953	Lynch	burg Virgi				
	and and			City, Town or Loc	cation				11	Od. Inside Øity Limits				
	Maryl f sho	ō	M11 17 14 77						"	1/Di Yes 2 □ No				
	28e	rect	Maryland Washington Ha	agerstow	n 10f. Zip Code		100	g. Citizen of V	What Count	-(				
	3a or		449 Clarendon Ave		21740			.S.A.	viidt Couri	.,.				
	death ms 2	<b>Funeral Director</b>	11. Marital Status 12. Was Decedent Ever in	U,S. 13. V		lispanic Origin? (Sp an, Mexican, Puerto			e - America	an Indian,				
0	after or ite	Ē	1 Never Married 2 Married Armed Forces? 1 Yes 2 No				Rican, etc.)		k, White, e					
02	rall,	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1	☐ Yes 2 No	Specify:		Specify	Whit	e				
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2	ithin Ben Me	du	Elementary/Secondary (0-12) College (1-4or 5+)			d)	9							
2	lygier	S	12 2	Home	maker			Domest						
Maryland 21215-0020	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other then "netural", or items 23a or 28e-f show atic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)				B (First, Middle, Ma		e)					
$\frac{8}{2}$	should and Men marke umatic	2	Charles Hubert Torrance				telle Pi							
<u>s</u>	and 2 sho ealth and n 27 Is ma	. 0	19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zip Code)						
	1 and Health em 27 Ather tr		William C. Ledford / Husband 20a Method of Disposition 20b		Land 21740 cation - City or Town, State									
ğ	Pages nent of h int: If Ite		1 ☐ Burial 2 Cremation 3 ☐ Removal from State											
Baltimore,	it. P.		4 Donation '5 Other (Specify)  21. Signature uneral Service License		g Cremat		1/26/05St	nitnsb	urg,	Maryland				
g	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "netural", or items 23a or 28e-f show any Injury or other treumatic event, the Medical Evarriner must be notified at once.		21. Signature Literal Saryte Literasure	- 1	Name and Addre	Res	t Haven			pe1 and 21742				
	*		23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory arres	t,		Approximate				
	Physician		, , , , , , , , , , , , , , , , , , , ,							Interval Between Onset and Death				
1	/Medical Examiner		Immediate Cause (Final disease or condition Pancreati	tis					1					
	LAdilline	resulting in death)  Due to (or as a consequence of):												
	ed sit	lue	h. Hypertrig	lycerdem	nia				i					
	rificate be executed ng physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
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28	ficate physis the	edic	resulting in death) Last  Due to (or as a consequence of):											
XOA	certii nding use a	M	d											
ň	death ce e attendii ad for use	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23b. Did tobacco use contribute to 1  Yes 2 No 3 Prol												
5	the cache													
	es that the death cer igned by the attendir be detached for use	by P					I L Tes	ZX NO	3   FIODE	ibiy 4 Onknown				
Kecords,	The law requires that the ate has been signed by the page 2 should be detache	Pa					24a. Was an a	autopsy		e autopsy findings lable prior to				
ပ္တ	aw re Is be	Completed					performe	u,	com	pletion of cause				
	The I	Ë					1 ☐ Yes	2√⊋No	1 🗆	Yes 2□ No				
<u>a</u>		Be	25. Was case referred to medical			26. Place of Death	(Check only one)							
<u>-</u>	hysicien: The law nis certificate has I I director, page 2 s	To	examiner? 1 to Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Oth	er:	me 5 🖾 Residence	e 6 □Othe	r (Specify)					
0 =	ig Pl		27. Manner of Death 28a. Date of Injury 1 ⊠Natural 5 □ Pending (Month, Day Year)	28b. Time of Injury	28c. Injun Worl	y at k?	28d. Describe how	injury occurre	ed					
<u> </u>	death. ctor: A y the fu	cati	2 ☐ Accident investigation			Yes 2 □ No								
DIVISION OF VITAR	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre cify)	et, factory, office		28f. Location (Stree City or Town, S	et and Numbe State)	or Rural	Route Number,				
2	urs a		00-0-45											
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  1☐ Certifying Physician: To the best of my known one)  1☐ Certifying Physician: To the best of my known one one of the basis of examination and manner stated.	nowledge, death nation and/or inve	occurred at the time of the stime ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and mar and place, a	nner as sta ind due to t	ted. he cause(s)					
	vith to t	Σ	29b. Signature and title of certifier		29c. License	e number	29d	Date signed	(Month, D	ay, Year)				
			P CENTURE WA		D0011	D0011266 November 21, 2005								
			30. Name and address of person who completed cause of death (Ite	em 23a) (Type, P	rint)									
H	,		Howard N. Weeks, MD 580 Nor	rthern A	ve. Hage	rstown, M	D 21742							
	Sta Registra		31. Date filed (MoNNOev, 2005) 32 degistrar's Sign		ule									

DHMH 16 Rev 6/95

			1 - For State Registrar	State	e of M	arylan		artmen rtificat			and M	lental Hy	giene Reg. No.	05	3	918	0 (
8	Physici		Decedent's Name (First, Middle	Last)								2. Date of De Month	eath Day	Ye	ar	3. Time of	
	/Medic	al	MILDRED			LAN	GSTON	45 65	T	1 2	( D	Novembe		200		3:53	/î M
10	Examir	er	4a. Facility Name (If not institution	•				LANH		Location o	t Death			County of D		CF	
	Funeral		DOCTORS COMMUNI  5. Social Security Number	6. Sex		e (In yrs.	last birthday)	If Under	1 Year	If Under:						ice (State o	r Foreign
	Director		226-22-1419	1 ☐ M 2 🔯	F 8	34	Yrs.	Months	Days	Hours	Min.	(Month, Da 10-14-				NIA	
	and		Usual Residence of Decedent  10a. State 10b. County			10c. Cit	y, Town or Lo	ocation							10	d. Inside Cit	tv Limits
	Maryl:	Į.		GEORGE			ITOL H		'C							<b>1</b> ∕ Yes	
	r 28a	Director	10e. Street and Number	GLORGI		OHI	TIOL I	10f. Zip					10g. Citiz	zen of What	Count	y?	
	th with	alD	1422 NYE STREET					207	43				U	S.A.			
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "naturel", or iteme 23e or 28e-f show other traumatic event, if a Medical Endulus finant Le notified at	Funeral	11. Marital Status	12. Was Ame	Decedent d Forces?	Ever in U	.S. 13.	Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,					)-	14. Race - A Black, W			
36		<b>by</b> Fu	1 ☐ Never Married 2 ☐ Marri 3X Widowed 4 ☐ Divorced	If Yes	d Forces? (es 2X) s, Give or Dates:	No		1 🗆 Yes		Specify:					BLA		
21215-0036			15. Decedent		OI Dates.		16a. Dece	dent's Usua	al Occupa	ation			16b. Kir	nd of Busine	ss/Indu	ıstrv	
215		plet	(Specify only highes Elementary/Secondary (0-12)		ted) ge (1-4or :	5+)	(Give	kind of wor DO NOT us	rk done d se retired	furing most )	of work.	ing	PRIV			,	
2		Completed		2	yrs		DE	AUTIC	LAN								
and		Be	17. Father's Name (First, Middle, IREV . HENRY B. W.	•						18. Mothe		e (First, Middle	, Maiden	Surname)			
7	2 should be and Mental Is marked of sumatic ev	ဥ			)	-	19h Maili	ng Address	/Street :				er City o	Town State	a Zin (	*ode)	
altimore, Maryland	ulth an 27 Is in traus		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St  1422 NYE STREET CAPITOL HEIGHTS, MD 20														
re,	is 1 and 2 of Health a Item 27 is other trai	20a. Method of Disposition  20b. Place of Disposition (Name of particular of particula												or Tow	n, State		
<u>im</u>	permit. Pages 1 an Department of Heal Important: if Item 2 any njury or other once.		4 □ Donation 5 □ Other (Specify) ARLINGTON NATIONAL 12-6-2005 TRIANGLE, VA														
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	20 2 6 Q		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,														
			shock, or heart failure. List	only one cause	on each li	ne.		er the mod	e or ayını	g, such as	cardiac (	or respiratory a	rrest,		1 1	Approximate nterval Bety Onset and D	ween
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	ocuted nd transii	Examlne	that initiated events	c.													
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387	physicate t	dlca		d.											1		
Вох 6	death certificate be executed e attending physician and nd for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pegnant at time of death 5 Other (specify)									23d. Date of delive				
B	death e atte	iclar	in the past 12 months?  1 Yes 2 No										Month			′ear	
P.O.	that the deby the	hys	9 Unknown	9□ Unknown													
	Se C5 0	þ	Part II. Other significant condition	4	to death b	ut not res	ulting in the u	nderlying c	ause give	n in Part I.				se contribute			
ord	w require been si should t	eted	Hypertens	ICM								10	Yes 22	<b>≼</b> No 3□	Proba	oly 4 UU	nknown
3ec	0 5 0	Completed										24a. Was autop			to com	sy findings a pletion of ca	
e	iician: The certificate ha rector, page	e Co	25. Was case referred to medical									1 ☐ Yes	2 No	1 🗆 Y		□ No	
5		o B	examiner?  1 Yes 2 No	Hospital:	1 🗌 Inpatie	ent 2%	ER/Outpatier	nt 3 DC	A Othe	NP:		me 5□Resi		Other (S	necity)		
Division of Vital Records,	iding Phys th. : After this funeral di	T:u	27. Manner of Death	28a. C	Date of Inju Month, Da		28b. Time o		8c. Injury Work			28d. Describe			pocny		
sior	Attending r death. sctor: After by the funer	atlo	1 Matural 5 Pending 2 Accident investig	ation		, . 52-7	,	М		res 2 🗆	No	_					
Ξ	or Attendation of Attendation of Director:	ertification;	3 Suicide 6 Could r 4 Homicide determi	nort 280. F	Place of Injouilding, et	ury - At ho c. <i>(Specif</i>	ome, farm, sti y)	reet, factory	, office			28f. Location ( City or To	Street and wn, State)	Number or	Rural	Route Numi	∂e <i>r</i> ,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	O	29a. Certifier 1€ Certifyin	Physician: T	o the hest	of my kno	wledge deat	h occurred	at the tur	e date and	d place	and due to the	Calleo(c)	and manner	ac ste		
	• Hos	dical		xaminer: On t	he basis o manner st	f examina	tion and/or in	vestigation,	, in my op	oinion, deat	h occurr	ed at the time,	date and	place, and o	lue to t	he cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier					290	. License	number			29d. Date	signed (Mo	onth, D	sy, Year)	
)	1		Steven Remsen D19446 Novembe									ne v	6,20	05			
)	12		30. Name and address of person	vho completed	cause of c	•						0704					
	0.			emse					LAN	HAM, I	MD 2	0/06	·				
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			For State Registrer	tate of Maryland	d / Depa		lealth an	d Mental H		•	39181
	Physici	90	1. Decedent's Name (First, Middle, Last)	-				2. Date of D	eath	_ Year_	3. Time of Death
	/Media	cal.	Margaret Jonscher	Lanigan						5, 2005	4:45P. M
1	Examir	ier	4a. Facility Name (If not institution, give stre Renaissance Gardens(		Villae	4b. City, Town, o	r Location of D r Sprir			County of Death	enroe!s
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. k	_	If Under 1 Year Months Days	If Under 24	_	irth	0 Rietho	place (State or Foreign of try). ngton, D. C.
	pu k		Usual Residence of Decedent  10a. State 10b. County	10c City	, Town or Lo	cation					Od Inside City Limits
	he Maryla 28a-1 shor	ector	Maryland Prince Georgian Too. Street and Number		ver Sp	ring		-	10 000		0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a or 3	al Dir	3160 Gracefield Road	d, #1113		10f. Zip Code 20904			Unite	en of What Cour ed State	es es
920	Dearnit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28a-1 show mips interpreted to the result of the mary injury or other traumetic event, The Marical Examination institutional and page.	by Funeral Director	11. Marital Status 12.  1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	,	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin an, Mexican, P Specify:	? (Specify Yes or Nuerto Rican, etc.)		4. Race - Americ Black, White, Specify: Wh	
21215-0036	n 72 ho "netur	Completed	15. Decedent's Educati (Specify only highest grade co		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of	working	16b. Kin	d of Business/Inc	dustry
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Maryland 2	2 should ba filed with and Mental Hygiene. is merkad other ther aumetic event, ITEM	To Be C	17. Father's Name (First, Middle, Last) Robert Anthony Jonso	cher				Name (First, Middle Slen Wells	e, Maiden S		or hary rand
	1 and 2 shou Health and N tem 27 is mai		19a. Informant's Name/Relationship (Type, Mary K. Lanigan -dau					r Rural Route Numi Beltsvil			
Baltimore,	ages 1 and of He		20a. Method of Disposition  Y□ Burial 2 □ Cremation 3 □ Rem			sition (Name of natory or other place		Date	V.	ation - City or To	
altin	parmit. Pages 1 Department of P Important: If ite any injury or ot once.		'4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	ALL							on, Virgini
	20 = 20	8 10	Wordd 15 or	1	<sub>1</sub> 44	00 Powde:	r Mĭll	Road Belt	svill	e, Mary	land 20705
	Physician /Medical	The state of the s	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death)	ons that caused the death ause on each line.  Lung Cance:  Due to (or as a consequence of the consequence of	r	er the mode of dyir	ig, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
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	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Liseas of Liseas	Due to (or as a consequ	ence or):						
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k 68	ertifica ling ph e as th	Med	IF FEMALE:								
P.O. Box	Physician: The law requires that the death certificat this certificate has been signed by the attending phy rail director, page 2 should be detached for use as the	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)			23	d. Date of delive Month	ry Day Year
	res that the de ignad by the a be detached to	by Ph	Part II. Other significant conditions contrib Coronary Artery Dise								e cause of death?
ord	w require been sig should t	eted		sabe, Empriyo	ina, o	diotid D.	isease,	_	Yes 2□		ably 4 □Unknown
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ΖΪ	sician: certific irector.	o Be	25. Was case referred to medical examiner?	oital:	-D/O	Oth		Death (Check only			
on of	iding Phys th. : After this s funeral dis			1 ☐ Inpatient 2 ☐ B 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	4€3 Nursir y at	ng Home 5 Res 28d. Describe			)
Division	after dea after dea Director d in by the	Certification;	3 Cuidide 6 Could not be	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stri	eet, factory, office			(Street and wn, State)	Number or Rura	Route Number,
	To the Hospital or Attending Pl within 24 hours after death.  To the Funerel Director: After the completely filled in by the funera	edical C	29a. Certifier (Check only one)  Check only one)  Check only one)	an: To the best of my know On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the tir restigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time	cause(s) a date and p	nd manner as sta lace, and due to	ated. the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	11		29c. Licens DOO022				signed (Month, L	
	1		30. Name and address of person who comp Christine DeLima, M.		Dusen	Road #26	io Laur	el. Marvi	and 2	0707	
:	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 7 2005	32 degistrar's Signat		arke)		,, -	J. 14 Z	0707	

			1 - For State Registrar	State of	Marylar	nd / Depa	artmer rtificat			nd Mer		giene neg. No. 05	39182
	Physic /Medi		Decedent's Name (First, Middle,     Agnes Madeling								Date of Dea		3. Time of Death 11:35 P M
	Exami		4a. Facility Name (If not institution,  Calvert Memor						Location of			4c. County of De	
	Funeral Director		5. Social Security Number 215–38–5416			last birthday) Yrs.		r 1 Year	If Under 24 Hours	4 Hrs. 8. Min.	Date of Birti (Month, Day ec 15	9. B	irthplace (State or Foreign Country) ryland
e Maryland	Sa-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Calve	rt		ity, Town or Lo	ocation						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
th with th	23a or 2		14360 Solomons	Island Ro	ad S.			688				10g. Citizen of What ( United Sta	
5-0036 72 hours after death with the Maryland	jene. Ir than "natural", or flema 23a or 28a-f ehow the Modical Examinar mant be nutified at	d by Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	12. Was Deced Armed Ford and 1 Tyes 2 If Yes, Give Year or Da	es? ! <b>⊠</b> No		Was Dece If Yes, spe	cify Cuba	spanic Origin, Mexican, Specify:	n? (Specify Puerto Rica	Yes or No- an, etc.)	14. Race - An Black, Wh Specify: Wh	
121 within	r than "	Completed	15. Decedent' (Specify only highest Elementary/Secondary (0·12) 6th	s Education ( grade completed) College (1-	4or 5+)	16a. Dece (Give life.	kind of wo DO NOT u	al Occupa ork done d ise retired,	ition luring most o )	of working		16b. Kind of Busines  Own hom	ŕ
Maryland 2	Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, L Robert Russell							s Name <i>(Fi</i>		Maiden Surname)	
	item 27 is mo		19a. Informant's Name/Relationsh David Langley –  20a. Method of Disposition		205	14360	) Sol	omons	s Is.	Rd. S	. Sol	omons, MD	20688
Baltimore,	rtmer		1 ⊈Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp  21. Signature of Eugeral Service L	ecity)	Ou	Place of Dispo cemetery, creat Lady			1			Solomons,	Maryland
Ba	Depo Impo		23a. Pan1. Enter the disease, or of	oc/		44	105 B	roome		rD.	Port I	neral Home Republic M	
8760, ate be executed III	hysician and Medical xaminer transit the prize transit	dicai Examiner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. O.A. Due to (o Due to (c. A.T.)	ch line.	quence of):		die S		mfe	veitra		Interval Between Onset and Death
P.O. Box 61	ed by the attending pl detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregrant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		h 2 ∏ Feta ntattime of o	aldeath 3	Ectopic p					23d. Date of d Month	elivery Day Year
	been signed by	þ	Part II. Other significant condition	ns contributing to dea	th but not res	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did to		to the cause of death?  Probably 4 □Unknown
Vital Records, sician: The law requires t	cete has bee	Completed									24a. Whas a autops perfori 1 ☐ Yes	by prior to	
Division of Vita	eath. tor: After this certificete ha the funeral director, page	Certification: To Be	25. Was case referred medical examiner?  1 Yes 2 No  27. Mary er of Death  1 Natural 5 Pending investig: 3 Suicide 6 Could no	28a. Date of (Month)	Injury Day Year)	ER/Outpatier 28b. Time of Injury	f A	28c. Injury Work 1 🔲 Y	r: 4 🗆 Nurs	ing Home 28d.	Describe ho	ence 6  Other (Sp ow injury occurred	~
5 6	ours after ceral Directilled in by		4 Homicide determin	ned 288. Flace of building	, etc. (Speci				a data con		City or Towi		
To the Hospital	within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one) 2   Medical E	xaminer: On the bas and manner	r stated.	ation and/or in	vestigation 290	c. License	inion, death	occurred a	t the time, d	ause(s) and manner at and place, and du	e to the cause(s)
	4		30. Name and address of person w	M.D. Hunti	ngtown	n Maryl	and 2		277A				
	Sta Registi	1	31. Date filed (Month, Day, Year)	1 4 2005	gistre's Signa	ature #	dos	the					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No... 1 Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 8,2005 CHARLES LANDIS BROOKE ove niber /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hagerstown

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 2. Date of Birth (Month, Day, Year) | 2. Date of Birth (Month, Day, Year) | 2. Date of Birth (Month, Day, Year) | 2. Date of Birth (Month, Day, Year) | 2. Date of Birth (Month, Day, Year) | 2. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (Month, Day, Year) | 3. Date of Birth (M Washington County Hospital Washington 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F Months Yrs. 214-16-0013 Director 84 Maryland Usual Residence of Deceden Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar ment of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic avent, the Medical Examinat must be notlined at 1 ☐ Yes 2X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20619 Emerald Drive 21742 .S.A. 2 should be filed within 72 hours after death in and Menial Hygiene.
is marked other then "naturel", or Items 23s Funeral 12. Was Decedent Ever in U.S. Amed Forces?

V Yes 2 D No
If Yes, Give
Year or Dates 1944-1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Engineering Draftsman Sand Blast Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hiram Landis Frank Mary Amanda ပ Buckingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Dorothy K. Landis 20619 Emerald Drive, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Rose Hill Cemetery 11-22-05 Hagerstown, Washington \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice Andrew K. Coffman Funeral Home, R. poel proa 40 East Antietam St., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Prysician  $\sim$ LN disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760. physician Physiclan/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probabiy 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Tes 2 No 24a. Was an certificate has 1 ☐ Yes 2 No the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 → No Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral C 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

DH-10+

Mame and address of person who completed cause of death (Item 23a) (Type, Print)

121 11110

32. Registrar's Signature

rederie

31. Date filed (Month, Day, Year) NOV 2 1 2005

			For State Registrar	State of N	<i>l</i> larylar				ealth and Death	Mental H	ygien Reg. No		39184
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Katherine Ida L	ucas						2. Date of I	_	შ05 <sup>Year</sup>	3. Time of Death 6:50A M
	Examin		4a. Facility Name (If not institution, give st Calvert County	reet and numbe Nursin	g Ce	nter			Freder		C.	alvert	ath
also	Funeral Director		5. Social Security Number 6. Sex 1	M 2 <b>½</b> F 7.7	Age (In yrs. 95	last birthday) Yrs.	If Unde Months	Days	If Under 24 Hrs Hours Min		ay,1 <sup>y</sup> 9*1	9. Bi	thplace (State or Foreign Yland
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Calvert		10c. Cit	ty, Town or Lo		rd					10d. Inside City Limits 1 ☐ Yes 2 ☐ ☆
	with the	i Direc	10e. Street and Number 5385 Long Beach Dr	rive				p Code 20685				itizen of What C United	
980	be filed within 72 hours after death with the Maryland hal Hygiene. od other than "naturai", or itema 23a or 28a-f ehow event, the Madical Examinar must be recilied at	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Deceder Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? <b>XN</b> o		Was Deci i Yes, sp 1 \( \text{Yes}	ecify Cuba	spanic Origin? () n, Mexican, Pue Specify:	Specify Yes or I rto Rican, etc.)	No-	14. Race - Am Black, Wh Specify:	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natur vent, Ine Madical I	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		or 5+)	16a. Dece (Give life. office	kind of w DO NOT	ork done d use retired	luring most of wo )	orking		Kind of Busines	s/Industry  Company
land ;	should be filed and Mental Hyg a marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) George B. Dove						18. Mother's Na Annie	me (First, Midd Hutchi		n Sumame)	
Baltimore, Mary	permit. Pages 1 and 2 should t Department of Health and Ment Important: if item 27 is marked any injury or other traumatic e once.		19a. Informant's Name/Relationship (Type Edward L. Lucas — 20a. Method of Disposition  1  Burial 2 **Cremation 3  Re 4  Donation 5 Other (Specify)  21. Signature of Euneral Service License	SON		5385 Place of Disponentery, creating the completery, creating the complete	Long sition (Namatory or tan ) 2. Name a	Beac ame of other place Funer and Addres	h Dr. St e)Nov 14 al Serv	Date 2005 ice Rausch	ard, 20c. t Alex Fune	MD 2068 cocation City of candria	35 r Town, State Virginia
8760,	Physician /Medical Examiner physician and physician and physician and the priting the priting the priting the priting the priting the physician and physicia	dicai Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consecutive as a c	eizum		dis	or der				Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Sc. If yes, outcor 1 Live birth 4 Pregnant 9 Unknowr	2 Feta t at time of c	al death 3	Ectopic Other (s	oregnancy specify)		TE Yethen	-	23d. Date of d Month	elivery Day Year
	uires that signed by Id be deta	ρ	Part II. Other significant conditions con	tributing to death	h but not re	sulting in the u	nderlying	cause give	en in Part I.				to the cause of death? Probably 4 Donknown
Vital Records,		Completed								24a. W au pe 1 🗆 Yes	topsy rformed?	prior to	autopsy findings available completion of cause of as 2 1 No
of	ing Physica n. After this ce funeral direction	ation: To Be	25. Was case referred to medical examiner? 1  Yes 2 No  H  27. Manne of Death 1 Matural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpa 28a. Date of In (Month,		ER/Outpatier 28b. Time o Injury		28c. Injury World	er: 4 Nursing	eath (Check online) Home 5  Re 28d. Describ	sidence	6 Other (Spury occurred	necity)
Division	ai or Atte s after des ni Directo ad in by th	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At h etc. (Speci		reet, facto	ry, office		28f. Location City or	(Street a own, Sta	and Number or I te)	Rural Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medicai (	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)		s of examin								
	To ti To ti Com	Σ	29b. Signature and title of certifier  5 Lav	MD			2	9c. Licenso	502			ate signed (Moi	1-05
250	3		THE RESIDENCE OF THE PARTY OF THE PARTY.	hah,	110,	Hosp	F	A TOWN	Prin	4 f	red	evicu	MD
1	Sta Regist		31. Date filed (Month, Day, Year)	32. Regi	istrat's Sign	nature #	do	este)					

			1- State of Maryland / Department of Health and Certificate of Death		giene 05	39185
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea	Day Year	3. Time of Death 1:00 P M
	/Medic	al	WILLIAM Alexander MACKENZIE  4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of De	11	28 2005 4c. County of Deat	
	Examin	er	FOREST HILL HEALTH & REHAB CENTER FOREST HILL		HARFORD	'
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year   If Under 24 F	Hrs. 8. Date of Birt	th 9. Birtl	nplace (State or Foreign
	Director		133-03-9390 87 Yrs.	11/21/1	918 New	York
	and w	1	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Maryl -f sho	tor	MD Harford Aberdeen			1⊠Yes 2 ☐ No
	r 286	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of What Co	untry?
	23e o	al D	500 West Bel Air Ave. Apt. 302 21001		U.S.A.	
	tems	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces? INTACT 13. Was Decedent of Hispanic Origin?  If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	14. Race - Ame Black, White	
36	rs afte	by F	1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No WWII  1 □ Yes 2 □ No Specify:  1 □ Yes 2 □ No Specify:		Specify: Whi	te
5-0036	72 hours after death with the Maryland natural', or tlems 23e or 28e-f show dical Examinat he indiffed at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business/	
2121	within 7 iene. than "r	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  (Give kind of work done during most of vife. DO NOT use retired)	working		
121	filed w Hygier Ather th		12 0 Military  17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Middle,	U.S. Gove	rnment
Maryland	2 should be filed within and Mental Hygiene. Is marked other than surmatic event, the Ms	To Be		O'Rourke	,	
ary.	should ind Men imarke	Ĕ	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or			ip Code)
	as 1 and 2 of Health a fitem 27 is r other train		Joan Collison (Niece) 405 Quaker Bottom Ro	d. Havr	e de Grace,	MD 21078
ore	of He of He if item or oth		20a. Method of Disposition  1 □ Burial 2 ▼ Cremation 3 □ Removal from State	Date	20c. Location - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importance of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examination in any injury or other traumatic event, the Medical Examination in any injury.		*4 Donation 5 Other (Specify) R. A. Ferris & Co. 11	/30/05	West Chest	er, PA
Bal	permit. Departr Imports any injs		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Tarring—Cargo Aberdeen, Mary			
ı			23à Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	diac or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. According to the condition resulting in death)	- la		
	Examiner			-7		
-	7 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
V	icate be executed physician and s the burial-transit	Examiner	that initiated events C.			
8760,	be exe	al E	Due to (or as a consequence of):			
687	ficate physis the	edica	d.		- 3	
Box (	death certificate e attending phys d for use as the	n/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of deli	very
	ne death the atte	sicia	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify)		Month	Day Year
P.0	at the	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23a Did to	bacco use contribute to	the sauce of death?
Records,	w requires that the de been signed by the a should be detached f	Completed by Physician/Medical	Part II. Other significant conditions continuating to death out not resulting in the underlying cause given in Part I.		res 2□No 3□Pro	<b>&gt;</b> - <b>&gt;</b>
Seco	> Q 7/3	nple		24a. Was	an 24b. Were au prior to comed?	opsy findings available ompletion of cause of
alF	ician: The law certificate has ector, page 2 9			1 Yes	2DNo 1□Yes	2 No
of Vital	Physician: this certifical	To Be	examiner?	Death (Check only o	ne) dence 6 □Other (Spec	ifu) *
J Of		n: T	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		now injury occurred	
sior	Attending r death. ector: After by the fune	atlo	2 Accident investigation M 1 Yes 2 No			
Division	s after de al Directe	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or Ru vn, State)	ral Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate of the basis of examination and/or investigation.	ace, and due to the courred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier 29c. License number		29d. Date signed (Month	Day, Year)
,			Da/50 D32255		Nevenbor	292005
	5×1		DR. DAVID DUNN, 615 W. MACPHAIL ROAD, BEL AIR, MARYL			,
	Sta Registi		31. Date filed (Month, Day, Year)  DEC 0 5 2005  32. Régistrar's Signature			

			For State Registrar	ate of Marylar		artment of H			ene g. <b>%</b> 0 0	5	39186
	Physicia	an.	Decedent's Name (First, Middle, Last)					2. Date of Death Month		Year	3. Time of Death
	/Medic	al	William Richard MOW			4. Ch. T.		November	1	005	6:24 A M
	Examin	er	ta. Facility Name (If not institution, give street) Ravenwood Lutheran V				Location of Death		4c. County o		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	Hagersto		8. Date of Birth	Washi		Π ace (State or Foreign ry)
- 1	Director		219-05-2889 <sup>1</sup> MM	2□ F 8	6 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Nov. 21	,1919	Mar	yland
	pu »		Usual Residence of Decedent  10a. State 10b. County	100 C	ity, Town or Lo	notion				140	ad Inside City Limits
	laryla ahov	5	Maryland Washingto		•					10	od. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ect	10e. Street and Number	011	п.	agerstown		10	g. Citizen of W	hat Count	
	with 3e or	ă	13811 Long Ridge Dri	.ve		217	42	10	USA	nat Oount	y :
	death	hera	11. Marital Status 12. W	as Decedent Ever in U	J.S. 13. V	Vas Decedent of Hi	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No-	14. Race		
ဖွ	after or ita	Fur	1 Never Married 2 Married 1	med Forces? XiYes 2 □ No Yes, Give		ryes, specify Cuba I ☐ Yes 2⊠ No	n, mexican, Puerto :  Specify:	Hican, etc.)		, White, e	<sub>hite</sub>
003	ours,	d by	3 N Widowed 4 Divorced Y	ear or Dates: WW	11				Specify:		
15-	"nati	lete	15. Decedent's Education (Specify only highest grade con		16a. Deced	lent's Usual Occupa kind of work done of OO NOT use retired	ation during most of workii i)	ng 1	6b. Kind of Bus	iness/Ind	ustry
12	withi	Completed by Funeral Director	Elementary/Secondary (0-12) C 12 0	ollege (1-4or 5+)		unting	,		publish	ning	company
þ	should be filled within 72 hours after death with the Maryland nd Mental Hygiene. I have smarked other than "natural", or itams 23e or 28a-f ahow umatic avant. I'm Medical Exar and the collided at	e C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	laiden Sumame	)	
/lar	uld b Menta Menta rked	To Be (	Howard F. Mowen				Agnes	B. Pome	roy		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23e or 28a-1 ahow any injury or other traumatic avant, the Medical Examment in the modified at one		19a. Informant's Name/Relationship (Type, P	*			and Number or Rura		•		ř
ő	1 and 1 ealth 1 ear 27 1 her tu		Frances Hardy - frie				, Hagerst		y Land 2 Oc. Location - C		
آور	ages nt of h		1⊠ Burial 2 ☐ Cremation 3 ☐ Remov	ai iiom State		sition (Name of natory or other place	l l				
量	nit. Pa artme prrtant injury		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee	K			ery   11/2 ss of Facility MI				Maryland
Ba	permi Depa Impo any ir		> South	Manne			lson Blvd				21740
	*		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	ns that caused the dea							Approximate Interval Between
الم	Physician		Immediate Cause (Final disease or condition	Mekashah	¿ Cala	N Canc	0 A J			5	Onset and Death
	/Medical		resulting in death)	Due to (or as a conse		Corn Co					- 100 .31
	Examiner	L	Sequentially list conditions, b	Atmoscl	insh						years.
	pel list	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Duá to (or as a consa	quence on:						1
	le be executed ysician and e burial-transit	Examiner	that initiated events c c	Due to (or as a conse	quence of):						
8760,	icate be executed physician and s the burial-transit	ical	d								
9	rtificat ng phy as th		IF FEMALE:								
Box	The law requires that the death certific tte has been signed by the attending pl bage 2 should be detached for use as t	by Physician/Med	23h Was decedent programs	yes, outcome of pregn □Live birth 2 □ Fet		Ectopic pregnancy			23d. Date Mont		y Day Year
hard P.O.	ne deg	yslci	1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	□Pregnant at time of □Unknown	death 5□	Other (specify)			IVIOITE		ouy rous
(1)	that the	Ph	Part II. Other significant conditions contribute	ing to death but not re	sulting in the ur	nderlying cause give	an in Part I.	23e. Did toba	acco use contrib	oute to the	cause of death?
Ric ds,	uires sign ld be	d b	osgamic	Brain!	Syndi	me		1 🗆 Yes	3 2 □ No 3	B ☐ Proba	bly 4 □Unknown
ecords,	w requires been si	lete	Perda Chim	e alicce	21			24a. Was an	24b. W	ere autop	sy findings available
T 00	The la	Completed		( 0.0( )==				autopsy perform	ed? de	or to com ath? ⊒Yes 2	pletion of cause of
Wil.		BeC	25. Was case referred to medical examiner?				26. Place of Death				
of V	Physic this ce al direc	To	1 ☐ Yes 2 ☑ No	I □ Inpatient 2 □	☐ ER/Outpatien		4 X Nursing Hon	ne 5 🗌 Resider	nce 6 Other	(Specify)	
N.	ing P		Tatalal O Tollaring	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		lad. Describe how	v injury occurred	d	
MOWEN	Attending Physician: r death. sctor: After this certification by the funeral director.	icat	2 Accident investigation 3 Suicide 6 Could not be	e. Place of Injury - At h	nome farm str		Yes 2□No	8f. Location (Stre	eet and Number	or Rural	Route Number
∑ ≥	lor A after Direct	Certification;	4 Homicide determined	building, etc. (Spec	ify)	sol, ractory, ornos		City or Town,		or riara	Tiodio (vambo),
	To the Hospital or Attending F within 24 hours after death. To the Funaral Director: After completely filled in by the funer.	alc	29a. Certifier 1 Certifying Physician	: To the best of my kn	owledge, death	occurred at the tim	e, date and place, a	ind due to the cau	use(s) and man	ner as sta	ted.
	he Ho in 24 he Fu	edical		In the basis of examin nd manner stated.	ation and/or inv			ed at the time, dat	le and place, an	id due to t	the cause(s)
	with To t	Σ	29b. Signature and title of certifier			29c. License	number	29	d. Date signed	(Month, D	ay, Year)
						1 24	7770		NOV ZZ	,	-
A 411	1-6+1	1	30. Name and address of person who comple	ted cause of death (Ite		Print)	4996 Rd Bz	onsbar	U MI	2/	7/2
11	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature						
	Registr		NOV 2 3 2005	Biles	M. A	miles					
DI	MH 17 Rev 1/20	001				1					

Please Type or Print in Black Indelible Ink	. Ensure All Copies Are	Legib
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		•	a roi	artment of Health and Men	ntal Hygier	11115 39167
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Floe Kathryn MARTIN		Date of Death Month D	Oay Year 2005 3. Time of Death 11:25 p.m.
	Examin		4a. Facility Name (If not institution, give street and number)  Homewood of Williamsport  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  Williamsport  If Under 1 Year   If Under 24 Hrs.   8,	Ţ	dc. County of Death
	Funeral Director		204-01-6023  Usual Residence of Decedent	Months Days Hours Min.	Date of Birth (Month, Day, Yea 2c. 18 1	9. Birthplace (State or Foreign Country) 919 Pennsylvania
	e Maryland ie-f show liffed at	ctor	10a. State 10b. County 10c. City, Town or Lo  Maryland Washington Hage	erstown	-	10d. Inside City Limits 1 ☐ Yes 2☐ No
	th with th	al Directo	10e. Street and Number  Route 4 — Martin's Crossroads	10f. Zip Code 21740	10g. (	Ditizen of What Country? USA
36	rs after dea I', or Items vaminer m	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes <b>②</b> No Specify:	Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "neturel," or Items 23a or 28e-f show eumetic event, the Madical Evantract must be notified at	Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired)		Kind of Business/Industry
and 21	d be filed wantal Hygier ced other tice event, the	Be	12 0 Ov  17. Father's Name (First, Middle, Last)  Clarence F. Meyers	ner  18. Mother's Name (File  Zola Kuhn		nvenience Store en Sumame)
Maryland	2 sho and Is m	2	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Rural Ro		
altimore,	Pages 1 and 3 nent of Health snt: If item 27 ary or other tr		20a. Method of Disposition 1♥ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, crei	Joann Drive, Odenton Sition (Name of natory or other place)  1 Mem. Cem. 11/23/	20c.	Location - City or Town, State  Liamsport, Md.
Baltii	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee 22		nich Fur	neral Home
	Physician /Medical		shock, or heart failure. List only one cause of each line.	er the mode of dying, such as cardiac or res	4	Approximate interval Between onset and Death
***	Examiner policy lands and policy poli	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.			
8760,	icate be executed physician and s the burial-transit	ical	resulting in death) Last  Due to (or as a consequence of):  d.			
P.O. Box 6	ath certif ittending or use a	Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
Records, P	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. HOCCCTH (ASI)		o use contribute to the cause of death?  2 No 3 Probably 4 Onknown
	icien: The law i certificate has b ector, page 2 sh	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2□ No
of Vital	S S D	To Be	25. Was case referred to medical examiner?  1  Yes 2 No			6 □ Other (Specify)
Division of		Certification:	1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office 28f.	Location (Street and City or Town, Sta	and Number or Rural Route Number, te)
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	ledical Ce	29a. Certifier (Check only one) 1 Medical Examinar: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and overtigation, in my opinion, death occurred a	due to the cause t the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
)	To the within To the Comple	Me	29b. Signature and illegar general MEDI CAR DIA COM	29c. License number	29d. C	Pate signed (Month, Day, Year)
5+	1-1		30. Name and address of person who completed cause of death (Item 23a) (Type,	Stanton Au	7.	tacas Jour las
₹.	Sta Registi		31. Date filed (Month, Day, Year)  NOV 2 1 2005  32. Registral's Signature	perke		21742

		for State Registrar		ia. y tarit	•	artment of F rtificate of				No.U	15	39188
Physic	0.00	1. Decedent's Name (First, Middle,	Last)					2. Date Mon	of Death th	Day	Year	3. Time of Deat
/Medi		John William M				T	1.77		mber		2005	5:45 PM
xamir	ner	4a. Fecility Name (If not institution,		r)		4b. City, Town, o		Death			ty of Death	
eral		Beverly Health 5. Social Security Number	Care S. Sex 7. /	Age (In yrs. Ia	ast birthday	Hagers If Under 1 Year		4 Hrs. 8. Date	of Birth		9. Birth	O11 place (State or Forentry)
al or		219-14-8164	1 <b>X</b> M 2□F	80	Yrs.	Months Days	Hours	Min. (Mor	h, Day, Y. h 2 1	925	Virg	ntry) ginia
		Usual Residence of Decedent										
	_	10a. State 10b. County		10c. City	, Town or L							10d. Inside City Lin 1 X Yes 2 □
	Director	Maryland   Washin	gton		Hage	rstown			10	0		
		10e. Street and Number				10f. Zip Code	17/0		109		f What Cou	ntry r
	Funeral	750 Dual Highway  11. Marital Status	12. Was Deceder	t Ever in U.S	S 13		1740	in? (Specify Yes	or No-	USA 14. Re	ace - Ameri	can Indian.
	E.	1 Never Married 2 Marrie	Armed Force:	s? ] No		Was Decedent of H If Yes, specify Cubi		Puerto Rican, e	tc.)		ack, White,	
	þ	3 ☐ Widowed 4 ☐ Divorced	od 1 X Yes 2 [ If Yes, Give Year or Dates	WW I	I	1 ☐ Yes 2X No	Specify:			Spec	ify: Whi	ite
	Completed	15. Decedent' (Specify only highest	s Education		16a. Dece	dent's Usual Occup	ation	of working	16	b. Kind of	Business/Ir	ndustry
	ple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	kind of work done DO NOT use retire	d)	of working				
	ပ္ပ	10	0		Guar	d					Gover	nment
	Be	17. Father's Name (First, Middle, L	_					's Name <i>(First, I</i>			ıme)	
	2	John William Mo		r.		(0.11)	1	nche Ine			04 . 7	0. (1)
once.	14.	19a. Informant's Name/Relationsh			2	ing Address (Street						
		Carolyn Ragland 20a. Method of Disposition	- Daughte	20b. PI	ace of Disp	George St		Haserst Date			21/40 - City or T	
		1 🔀 Burial 2 ☐ Cremation		ie Cé	emetery, cre	matory or other pla		1/22/200				, Marylan
٠		* 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service L		Ced		wn Mem. F 2. Name and Addre				_		
once.		150000	D 05		7.1	15 E. Wil						
		23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that caus	ed the death								Approximate
n		Immediate Cause (Final	nry one cause on each	ine.								Interval Between Onset and Death
i		disease or condition resulting in death)	a. Due to lor a	as a consequ	uence of):							48horis.
r			Re	uce o l	ailen	v						48 has
	je	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or a	as a cons	uence of):							
	Examiner	that initiated events	c									.,,,
	EX	resulting in death) Last	Due to (or a	as a consequ	uence of):							
	lical		d						<del>.</del>			
	Physician/Med	IF FEMALE:	22e If up a outpor	a of progra	•							
	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fetal	death 3	☐Ectopic pregnanc	у				ate of deliv Ionth	ery Day Year
	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant 9□Unknown		saun 5	Other (specify) _						
	Ph	Part II. Other significant condition	s contributing to death	but not resu	ulting in the	underlying cause giv	ven in Part I.	236	. Did tobac	cco use co	ntribute to t	the cause of death?
	d by								1 🗌 Yes	2 🗌 No	3 🗌 Proi	bably 4 DUnkno
	Completed							24a	. Was an	24b	. Were auto	opsy findings availa
	dmi							_	autopsy performe	d?	prior to co death?	ompletion of cause
, pag	ပိ	25. Was case referred to medical					26 Place	of Death (Check	Yes 2	(No	1 🗆 Yes	2 NO
	To B	examiner?	Hospital: 1 □ Inpa	atient 2□	ER/Outpatie	int 3 DOA Oth		sing Home 5		e 6 □0	ther (Speci	fv)
completely lilled in by the luneral director, i		27. Manner of Death	28a. Date of In		28b. Time		ry at		cribe how			**
	atlo	1 Natural 5 Pending 2 Accident investig	etion	, , , ,	111,017		Yes 2□N	lo				
	tific	3 Suicide 6 Could n	and 280. Place of	Injury - At ho		treet, factory, office			ation (Street		nber or Run	al Route Number,
	Certification:		3,					1				
	edical	29a. Certifier 1 Certifyin	Physician: To the be xaminer: On the basis	st of my kno	wledge, dea tion and/or i	th occurred at the ti	me, date and	place, and due	to the caus	se(s) and no	nanner as s	stated. to the cause(s)
	Medi	one)	and manner			29c. Licens						
	2	29b. Signature and title of certifier	a Stral						590	. Date sign	eu (Month,	Day, Year)
			J. A	)			8365			" ( /	4 ("	V
	,	30. Name and address of person v			23a) (Type	Print)	~ 6-	1200	1	1	102	1740
-		Tel AN 2 AN.  31. Date filed (Month, Day, Year).	7544C	3 trar's Signa	ture 10	Print)	cut 1	rugus	temi	1	(0)2	
	ate trar	31. Date filed (Month, Day, Year)	2005	w /	1. p	perte						
					. /							

		-	For State Registrar	State of M	aryland /		artmen tificate					iene	)5 (	3918	9
	Physicia /Medic	an al	Decedent's Name (First, Middle,	CODEMUS			4b. City.	Town, or	Location	]	Date of Deat Month NOVEMBE	r <sup>Day</sup> 20,	2005	3. Time of D 2130	Death M
	Examin	G1	5729 MT. CARMEL	CHURCH ROAL	e (in yrs. last b	nirthday)	If Under	I	BOONS.	BORO	Date of Birth		WASH	INGTON	Foreign
	Funeral Director		217-28-6883 Usual Residence of Decedent	1 <del>2</del> M 2□F	73	Yrs.	Months	Days	Hours	Min.	Date of Birth Month Day, EC. 7,	1931		RYLAND	, orongin
	Maryland a-f show	tor	10a. State 10b. County	SHINGTON	10c. City, To	wn or Lo	cation	ВС	OONSB	ORO			1	0d. Inside City 1 ☐ Yes 2	
	with the	i Direc	10e. Street and Number 5729 MT. CARMEL	CHURCH ROAL	)		10f. Zip	Code	2171	3	1	0g. Citizen o	of What Cour		
936	in 72 hours after death with the Maryland "natural", or thems 23a or 28a-f show circal Examinat must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☒ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?	Ever in U.S.		Was Deced f Yes, spec		spanic Ori n, Mexican Specify:		fy Yes or No- can, etc.)		ace - Americ lack, White, city:		
21215-0036	within 72 ene. than "na	Completed	15. Decedent (Specify only highes: Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or		(Give	DO NOT us	rk done d	during mosi )	t of working	'		Business/Ind	dustry PROD.	MAN.
Maryland 2	be filed tal Hyg d othe	To Be C	17. Father's Name (First, Middle, L WELTY CALVIN NI		•						First, Middle, M NCES MA		ame)		
	as 1 and 2 shof Health and of Health and itam 27 la m rother traum		19a. Informant's Name/Relationsh  ANNA M. NICODEM  20a. Method of Disposition  1 □ Burial 2 □ Cremation	US, WIFE	20b. Place cemet	5729 of Dispo	MT. sition (Nam	CARI ne of other place	MEL C	HURCH Dat		BOONS:	BORO,	MD 21	713
Baltimore,	permit. Page Department Important: If any injury or		4 □ Donation 5 □ Other (Sc 21. ⇒ pature of Fune II Sop 5 L		BEAVE	22	REEK ( R. Name an BAST I	d Addres	s of Facilit	ty	/2005 7606 OI BOONSBO	D NAT	IONAL		
	Physician /Medical Examiner	iner	23a. Part Fenter the disease, or shock, or heart failure. List of the control of	aDue to (or as	a consequence	e of):	er the mod		g, such as		respiratory arre	est,		Approximate Interval 8etwo Onset and De	
8760,	death certificate be executed e attending physician and of for use as the burial-transit	lical Examine	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence	e of):									
O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		Ectopic pr Other (sp						Date of delive Month	ory Day Ye	ear
rds, P.	signed d be de	by	Part II. Other significant conditio	ns contributing to death t	out not resulting	in the u	nderlying c	ause give	en in Part I		23e. Did tob	_		ne cause of dea ably 4 □Un	
Record		Completed	<u> </u>					<u> </u>			24a. Was a autops perform	٧	prior to cor death?	psy findings av npletion of cau	vailable use of
of Vital	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1 Yes 25. No  27. Manner of eath	Hospital: 1 ☐ Inpati 28a. Date of Inju		. Time o		OA Othe	er: 4 □ Nu	ursing Home	Check only on $5\overline{X}$ Resided. Describe ho	ence 6 🗆 C		/)	
Division	al or Attanding F after death. I Diractor: After d in by the funer.	Certification:	Accident 5 Pending investig 3 Suicide 6 Could related	ation ot be 28e. Place of In		Injury farm, str	М	1 🗆 '	Yes 2□		f. Location (St. City or Town		mber or Rura	l Route Numbe	er,
	To tha Hospital o within 24 hours aff To tha Funaral D completely filled in	Medical C	29a. Certifier (Check only one) Certifyin 2 Medical I	g Physician: To the best Examiner: On the basis of and manner st	of examination a	lge, deat and/or in	h occurred vestigation	at the tim , in my of	ne, date an pinion, dea	nd place, an oth occurred	d due to the ca at the time, da	ause(s) and a ate and place	manner as si e, and due to	ated. the cause(s)	
)	vithin To t	×	29b. Signature and title of certifier	lan	rela	A) (Type	MD	c. License	number	64	13	9d. Date sign	ned (Month,	Day, Year)	747
54	-5		30. Name and address of person.  31. Date filed (Month, Day, Year)	lama	rar's Signature	т, (туре,	ND		30	00	ALC	Ti	Hage	Notow	n, MD
	Sta Regist		NOV 2 1	2005	M.	Sp	artis						7		

State of Maryland / Department of Health and Mental Hygiene) [] 5 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Ruth Lewis Normandy 15, 5:30 PM Nov. 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northampton Manor Nursing Home Frederick Frederick If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Days Hours 217-58-3956 1 ☐ M 2 🔯 F Director 6. 1907 D. Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examiner must be notified at 1 Xes 2 No MD Frederick Middletown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ō 5 Lombardy Dr. 21769 USA Itame 23a Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. parmit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Importent: If Item 27 Is marked other then "natural", or Iter 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ Specify: White 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Herndon Myers Lewis Grace W. Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Miller (Daughter) 5 Lombardy Dr., Middletown, MD 20b. Place of Disposition (Name of cometery crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buria/ 2 Cremation, 3 Removal from State Rock Creek Cemetery11/18/05Washington, D. C. 5 Other (Specify) Funeral Service DonaldddBsofFTWompson Funeral Home any 31 E. Main St., Middletown, MD 27a. Part1. Enje shock, og h er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-trai Due to (or as a consequence of): P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day 4 Pregnant at time of death 5 Other (specify) the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 5 Residence 6 Other (Specify) PZ No 1 🗌 Yes 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Manner of eath 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Injury Netural Accider 5 Pending death. 1 ☐ Yes 2 ☐ No Accident investigation Director: 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours a Hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and itle of certific 29d. Date signed (Month, Day, Year) 30. Name and address of perso

Registrar

		For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of H		nd Mental Hy	giepe	5 39191	
a giff gran		1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	eath Day	3. Time of Dear	th
Physic /Med		ALMA	LOUISE	NEHOUSE			Novembe	er 16, 2	2005 7:38 P	М
Exam		4a. Facility Name (If not institution,	give street and number	er)	4b. City, Town, or	Location of D	Death	4c. County		
	. F	Frederick Memor			Frederi		Hre la Data ( B		derick	
Funerà		5. Social Security Number 213-56-4117	3. Sex 7. 1 ☐ M 2 ☑ F	Age (In yrs. last birthday 56 Yrs.	Months Days		Min. (Month, Da	ay, Year)	Birthplace (State or For Country)	eign
Directo	4	Usual Residence of Decedent					June 2	5, 1949	Maryland	
yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Lin	nits
a-fs	ctor	Maryland Freder	ick	Mt. Airy	7				1 🗆 Yes 2 🔀	No
ith the	Directo	10e. Street and Number		•	10f. Zip Code			10g. Citizen of	What Country?	
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er de	Funeral	11. Marital Status	12. Was Decede Armed Force	is?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin n, Mexican, P	n? (Specify Yes or No Puerto Rican, etc.)		ce - American Indian, ick, White, etc.	
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21215-UU36 4 within 72 hours after death with the Marylan jiene. I then "naturel", or items 23e or 28e-f show the Medical Exame must be notified at	led	15. Decedent's	Education	16a, Dece	edent's Usual Occupa	ation		16b. Kind of B	Business/Industry	
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Mar id 2 sho lith and 27 is m		19a. Informant's Name/Relationshi Larry Nehouse/Hu			-		or Rural Route Numb ad, Mt. A			
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Baltimore, permit. Pages 1 ar Department of Hea Important: If Item eny injury or othe		1 Burial 2 ☐ Cremation		ite cemetery, cre	matory or other plac		/21/2005		i	
ITIN pit. P. artme ortan injury		4 □ Donation 5 □ Other (Special Services 1)		Kestnaver	Mem. Gar	dS. 11	Stauffer	Frederi	ick, MD 21702	
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ecute and I-trans	хаш	that initiated events resulting in death) Last	c	as a consequence of):						
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68/ ifficate g phys	edical		d							
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. 0 00	icia	in the past 12 months? 1 ☐ Yes 25 No	4☐Pregnan	t at time of death 5	□Ectopic pregnancy □ Other (specify)			Mo	onth Day Year	
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Syned Spreed be de	by F	Part II. Other significant condition	s contributing to deat	h but not resulting in the	underlying cause give	en in Part I.			tribute to the cause of death'	
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ecc law r nas be	Completed						24a. Was	psy	Were autopsy findings available prior to completion of cause	able of
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VITAI REC rsician: The law s certificate has b director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		ont all post Other	0.50	f Death (Check only			
Division of Vital Records, or Attending Physician: The law requires I after death.  Director: After this certificate has been signs in by the tuneral director, page 2 should be	2	1 ☐ Yes 2 Ø No 27. Manner of Death	1 ☐ Inp		III JU DOA	4   Nuisi	ing Home 5 ☐ Res	idence 6 Oth how injury occur		
Vision of Vita Attending Physician: rr death. ector: Atter this certifici	ertification:	Natural 5 Pending 2 Accident investiga	(Month,	Day Year) Injury	Work	k? Yes 2 ∐No		mon injury occur		
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Div	Cert	4 Homicide	building	, etc. (Specify)			City or 10	wn, State)		
DIVISION To the Hospital or Attention 24 hours after deatl To the Funeral Director:	edicai (	29a. Certifier 11 Certifying (Check only 2 Medical E	Physician: To the be	est of my knowledge, dea s of examination and/or i	th occurred at the tim	ne, date and p	place, and due to the	cause(s) and m	anner as stated.	
the H nin 24 the F nplete	ledi	one)	and manner	stated.						
To To	Σ	29b. Signature and title of certifier.	Valla	1D_	29c. License			,	ed (Month, Dey, Year)	
			0011		D 4	-8184		111171	05	
4		30. Name and address of person w	no completed cause	of death (Item 23a) (Type	th Stree	t Fre	ederick , A	1D 21	1701	
S	tate	31. Date filed (Month, Day, Year)	32. Reg	ist of 's Signature	1					
Regis		NOV	1 8 2005	of death (Item 23a) (Type 50 W 7	sporte					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month November 9, 2005 **Physician** Noble, Sr. Robert Everette 11:43 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Takoma Park Montgomery Months Days Hours Min. 8. Date of Birth (Month, Day, Par) May 22, 1944 9. Birthplace (State or Foreign 6. Sex 1 M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Maryland 61 213-42-7745 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show r than "natural, or items 23a or 28a-f shov tre Medical Exerciser must be notified at 1 ☐ Yes 2 🛮 No Funeral Director MD Prince George's Capitol Heights 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20743 9406 Eugenia Park Place U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 1062 6 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1963–68 1 ☐ Yes 2 No Specify: Specify: white Be Completed by 3 ☐ Widowed 4 🔀 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) service station manager 12 .. Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: if Item 27 is marked other taury or other traumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Claude Noble Betty Jane Winterhak 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robert E. Noble, Jr., son 3561 Kelsey Way, Prince Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if eny injury or once. MD Veterans Cemetery 11/16/2005 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature > Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD back 20736 23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Myocardial Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Drabeter Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant at time of death P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ page 2 should be Hyperterning 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed old sugrandinfaction 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2□ No Morbid Oblisty, Hyper cholester demia 1 ☐ Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No After thi 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide l 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Silmutally 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8100 good lack Rd, Funker , MD 20706 31. Date filed (Month, Day, 32. Registra s Signature State 2005 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** ELMINDA GRIMMELL OLIVER NOV 13 2005 12:14 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY 8. Date of Birth (Month, Day, Year) 10/19/1925 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 XF Yrs. 80 Washington, DC **Director** 578-24-3861 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location rai', or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No Director Maryland Prince Georges Bowie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20716 12700 Haskell Lane o filed within 72 hours after death wat Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Contract Administrative OfficerFlight Simulation 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny jinjury or other traumatic event 2008. Be George C. Grimmel Geralda Duffield ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12700 Haskell Lane Bowie, MD 20715 Richard J. Oliver/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Cemetery 11/18/2005 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licens 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIC NON SMALL CELL LUNG CANCER **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the attending physicien and hed for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown cate has been signed by I page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 XNO Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No 2 1 X Inpatient 2 ☐ ER/Outpatient 3□ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H.D. 14 05 0101237286 (VA)

State

Registrar

NATIONAL NAVAL MEDICAL

BETHESDA MD 20889-5600

30. Name and address of person who concleted cause of death (Item 23a) (Type, Print)

2005

LCDR MC

32. Pogistrar's Signature

RICHARD A. CATHERINA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 10d per fh g850 12-5-05 vt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Della Kate Cropper Parker 2005 November 23 /Medical 4b. City, Town, or Location of Death 4c. County of Death .. 4a. Facility Name (If not institution, give street and number) Examiner REGIONAL MEDILA 344/3641 KIROMIO If Under 1 Year | If Under 24 Ars. 8. Date of Birth (Month, Day, Year) Aug. 16, 1914 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days ountry MD 1□M XXF Hours 218-20-5039 91 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State f Health and Meniel Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f ahor other traumatic avant, tra Medical Executant must be notified at 1 TYes X No Director Salisbury Wicomico 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 9288 Hickory Mill Rd. 21801 US permit. Pages 1 and 2 should be filed within 72 hours after death v. Depertment of Health and Mentel Hygiene important: If Item 27 is marked other than "natural", or Itams 23a amp injury or other traumatic event, the Medical Exemples research Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager School 3 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Minnie Mitchell Mott Cropper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia L. Cropper 10120 Waterview Dr., Ocean City, Md. 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t)

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Sunset Memorial Park | 11-26-2005 | Berlin, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service License 108 William St., Berlin, Md. 21810 lula 23a. Part1. Enter the disease, or complications that day sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final TISISTILE **Physician** disease or condition resulting in death) /Medical Que to (or as a consequence of) Examiner CAMPONASCOURN DISERST THERUSCIENTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner anding physicien and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy etter for u in the past 12 pronths?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) cete hes been signed , page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Minknown DEMENTA 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 No director 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 Tes 2 No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Illed in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

11/22/05

DK SAUSBURY MD 21804

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EASTEAN SHAKE

**ORIGINAL** 

State Registrar

alleller

1-11-11MMAGAYHEYZA

DEC 0 5

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614

32. Registrar's Signature

DHMH 17 Rev 1/2001

the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

certificete

this

within 24 hours after death. To the Funaral Director: Al

Hospital

Box 68760.

P.O. 1

Records,

Division of Vital or Attanding Physician: or 28a-f ahov

			For State Registrar		State of N	Marylan		rtment of H		nd Mental Hy	giene 05	39195
	Physicia /Medic		1. Decedent's Name (Fire William L.	st, Middle, Lasi Payte	)					2. Date of De Month		3. Time of Death 3:00 PM M
	Examin		4a. Facility Name (If not a			ər)		4b. City, Town, or Riverdale	e, MD		4c. County of E	orge's
	Funeral Director		5. Social Security Number 430-01-12	87 19	× ]M 2□F	Age (In yrs. 95	Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bir (Month, Da March	9. 25 <b>,</b> 1910 <b>M</b>	Birthplace (State or Foreign Country) bile, AL
	Maryland f show led at	or	10a. State 10b	. County ince Geor	ge's		y, Town or Lo nple Hil					10d. Inside City Limits
	3a or 28a	il Director	10e. Street and Number 4710 Buck C	reek Driv	æ			10f. Zip Code	20748		10g. Citizen of Wha	t Country?
036	be filed within 72 hours after death with the Maryland stal Hygiene.  do other than "naturel", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4		12. Was Decede Armed Force 1 Yes 25 If Yes, Give Year or Date	s? ₹ <sup>No</sup>		Vas Decedent of H f Yes, specify Cuba	ispanic Origin In, Mexican, I Specify:	n? (Specify Yes or No Puerto Rican, etc.)		American Indian, White, etc. Black
21215-0036	e filed within 72 hc al Hygiene. I other than "natur vent, Inv Wed cal	Completed		Decedent's Edi nly highest grad (0-12)			(Give life. l	lent's Usual Occupi kind of work done to DO NOT use retired cer Carrier	during most o d)	of working	16b. Kind of Busin U.S. Postal	·
	ould be filed Mental Hygid tarked other tatic event, II	To Be C	17. Father's Name (First, Willie Flet		æ					s Name (First, Middle 1 L. Matthew		
Maryland	od 2 sh lth and 27 Is m r traum		19a. Informant's Name/I LaVame A. Hin	Relationship (T es-Harris	ype, Print) Son/Goddau	ghter	19b. Mailir 3921 S	g Address (Street Sunflower C	and Number ircle	or Rugal Route Numb Bowie, MD 2	per City or Town, Sta 0721	ite, Zip Code)
Baltimore,	Pages 1 an nent of Heal nt: If item 2 iry or other		20a. Method of Dispositi 1 X Burial 2 ☐ Cro 1 4 ☐ Donation 5 ☐	emation 3 🗀		ite C	emetery, cren	sition (Name of natory or other place ven Cemete	ry No	Date v. 21, 2005	20c. Location - City Silver Sprin	
Balti	permit. Pages Department of H Important: If ite any Injury or of QDCB.		21. Signature of Funeral	Service Licens	ell	8_				Tyrone J. NW Washingt		
8760,	Physician /Medical Examiner	cai Examiner	23a. Part1. Enter the dishock, or heart fail Immediate Cause (Final disease or condition resulting in death)  Sequentially list condition fany, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	yre. List only o	a. Due to (or Due to (or c.	as a consequence as a c	uence of):  7/2  uence of):			ardiac or respiratory a		Approximate Interval Between Onset and Death
P.O. Box 68	ne death certifics the attending pl hed for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregin the past 12 mon 1 □ Yes 2 □ No 9 □ Unknown	gnaint	23c. If yes, outcor 1 □ Live birth 4 □ Pregnan 9 □ Unknowr	n 2 □ Feta t at time of d	Ideath 3□	Ectopic pregnancy Other (specify)	,		23d. Date of Month	f delivery Day Year
	uires that the signed by Id be detac		Part II. Other significant  OEME			h but not res	ulting in the u	nderlying cause give	en in Part I.			te to the cause of death?  Probably 4  Unknown
Records,	The law requirete law requirete has been single 2 should	Completed by	INFRE	TED	DEC	UB1	TIS	ULCE	L	24a, Was auto perfo 1 □ Yes	psy prior deat	re autopsy findings available r to completion of cause of th? Yes 2□ No
Vital	Physician: Th this certificete ral director, pag	Be	25. Was case referred to examiner?	-	Hospital:			Oth	05	of Death (Check only		
of	ding Phys	ion: To		Pending	28a. Date of I		28b. Time of Injury	28c. Injun	4 Figure		how injury occurred	Specify)
Division	I or Attending efter death. Director: After i in by the fune	Certification:	2 Accident 3 Suicide 6 4 Homicide	investigation Could not be determined	288. Place of	Injury - At he , etc. (Specif	ome, farm, str	eet, factory, office		28f. Location (	(Street and Number own, State)	or Rural Route Number,
_	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: After this certificete h completely filled in by the funeral director, page	edical C	29a. Certifier 1 (Check only one)	Certifying Phy Medical Exam	rsicien: To the be iner: On the basi and manner	s of examina	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due to the occurred at the time,	cause(s) and manne date and place, and	or as stated. due to the cause(s)
	To the To the compl	Me	29b. Signature and title	of certifier	3,1		YSAIM	29c. Licens	e number	1547	29d. Date signed (M	Month, Day, Year)
2	(3)		30. Name and address of	of person who	completed cause of	of death (Item	n 23a) (Type,	Print) ANDUSE	N PI	1 #27	1 64 12 RC	MA 2070,
	Sta Regist	ate rar	31. Date filed (Month, D NOV 2	ay, Year) 1 2005	2. Reg	istrar's Signa	dature	E)				

	1	For State Registrar	State of Ma	aryland /		artment of H tificate of L			giene Reg. No.	05	3919	6
Physicia	ın	1. Decedent's Name (First, Middle, L						2. Date of Dea Month Novemb	Day	1, ŽÕÕ5	3. Time of De	eath A - M
/Medic Examin	al -	Edward John Pres 4a. Facility Name (If not institution, gi	ive street and number)			,	Location of Death		4c. C	ounty of Death	1	
Funeral Director		Anne Arundel Med 5. Social Security Number 6. 212-82-1078		r e (In yrs. last b 46	oirthday) Yrs.	Annapoli If Under 1 Year Months Days	S If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da 09/13/	h	e Arund 9. Birth Cou Mary	pplace (State or F intry) 'Land	oreign
ryland how		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation			<del></del>		10d. Inside City I	
h the Mai r 28a-f s	Funeral Director	Maryland Prince (	Georges	Laurel	1	10f. Zip Code			10g. Citize	en of What Cou		
death wil	nerai D	12705 Duckettown  11. Marital Status	12. Was Decedent	Ever in U.S.	13.	20708 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No	USA 14	I. Race - Amer Black, White		
U.S after on items.	þ	1X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 ☐ Yes 2 ② 1  If Yes, Give Year or Dates:	No	)	1 ☐ Yes 2 No	Specify:	rtioari, oto.,		Specify: Whi		
Maryland 21213-UU30 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other than "natural", or items 23a or 28a-f show traumatic event, Ita Modical Examinar must be notified at	Completed	15. Decedent's (Specify only highest g	Education grade completed)  College (1-4or 5	(+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work ()			of Business/l		
C Z I.	е Соп	11 17. Father's Name (First, Middle, Lat	st)	He	eati	ng & Air	Technicia 18. Mother's Nam			ing & A	Air	
aryland should be and Mental marked o	To Be	Henry Albert Pr			Ob. 14-11:	ng Address (Street	Patricia				in Code)	
mary Mar and 2 sh ealth and n 27 is m		19a. Informant's Name/Relationship Henry A. Presley				Yoland S						
IMOFE Pages 1 nent of Hi ant: If iter		20a. Method of Disposition 1		La	tery, crei nhạm	osition (Name of matory or other place I United It Church	εθ)     11/1	5/2005	Lanh	ation - City or T		
Balti permit. Departin Imports any inju		21. Signature of Funeral Service/Lic	ensee			2. Name and Addre					rai nome	
Medical Examined be executed by sician and the burial-transit the burial-transit by the	dical Examiner	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlyind Cause (Disease or injury that intitated events resulting in death) Last	a. Due to (or as b. Due to (or as c.		ce of):	l hem	orrha	ge.			Onset and De	dil
, P.O. BOX 65 that the death certific sed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		□Ectopic pregnanc □ Other (specify) □			23	3d. Date of deli Month	very Day Ye	ar
Ords, P.O requires that the neen signed by th hould be detache	by	Part II. Dther significant condition	s contributing to death t	out not resulting	g in the u	underlying cause giv	ven in Part I.			e contribute to	the cause of dea	
Rec he law e has b	Completed							24a. Was auto perfe 1 \( \text{Yes}		prior to death?	topsy findings av completion of cau	railable use of
Vita sictan: certific irector,	o Be C	25. Was case referred to medical examiner?	Hospital:	ent 2□ER/	(Outnatie	ent 3 DOA Oth	26. Place of Dea	th Check onlone 5 Res		□Other (Spec	cify)	
n of ng Phy fter this ineral d	-	27. Manner of Death  1 Natural 5 Pending 2 Accident investiga	28a. Date of Inju (Month, Da	ury 281	b. Time of Injury	of 28c. Inju Wo		28d. Describe				
Division tel or Attending s after death. el Director: Afte	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad Zoe. Flace Ul III	jury - At home tc. (Specify)	, farm, si	treet, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Ru	ural Route Numbe	9 <i>r</i> ,
Hospii 4 hour Funer ely fill	edical C	29a. Certifier  (Check only one)  Certifying  Certifying  Description	Physician: To the best xaminer: On the basis of and manner s	of examination	dge, dea and/or ii	th occurred at the transversigation, in my	me, date and place opinion, death occu	, and due to the rred at the time	cause(s) a date and	and manner as place, and due	stated. to the cause(s)	
To the I vithin 2 To the I complete	Me	29b. Signature and yele of certifier	Dep, u	ND		29c. Licens	se number 5 8 5 / C	)	29d. Date	signed (Monti	h, Day, Year)	
		30. Nall and address of person w	~~~	death (Item 23		AAN	IC.			-		
St Regist	ate rar	31. Date filed (Month, Day, Year)		trar's Signature		freely "						

ORIGINAL

1	,	-	1- For AMEND#5,8 11/29/05 Per FH Registrar AACO HEALTH DEPT (MH	Marylan	d / Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth a Death	and M	ental Hyç	giene	005	391	97
	*		Decedent's Name (First, Middle, Last)							2. Date of Dea Month	Day	Year	3. Time of	Death
	Physicia /Medic		Dimitri William Pantazes							11/10/			8:40	AM
	Examin	er	4a. Facility Name (If not institution, give street and number	_		4b. City, T		Location o	f Death			County of Deat		
			Southern Maryland Hospita.  5. Social Security Number 6. Sex 7. A		ast birthday)	Clint If Under 1		If Under	24 Hrs.	8. Date of Birtl		ince Ge	hplace (State or untry)	r Foreian
	Funeral Director		219-90-5839 1XM 2□F	48 5	6 Yrs.	Months	Days	Hours	Min.	(Month, Da) 01/05/-	1957	Wash	ington,	DC
	9		Usual Residence of Decedent											
-	how det	_	10a. State 10b. County		, Town or Lo								10d. Inside Cit 1 ☐ Yes	
:	8a-1	Directo	Maryland   Prince Georges	Gle	enn Da		0-1-				10- 6::-	en of What Co	<u> </u>	
3	Den Z		10e. Street and Number			10f. Zip (					USA	en or what Co	untry?	
2	18 23	era	6820 Hill Meade Road  11. Marital Status 12. Was Deceder	nt Ever in U.	S. 13.			spanic Orie	gin? (Spe	crfy Yes or No- Rican, etc.)		4. Race - Ame	rican Indian,	
	iner iner	Funeral	Armed Forces	s?	1		_		, Puerto I	Rican, etc.)		Black, Whit	e, etc.	
<u> </u>	nous arer bean win ne maryand tural', or Items 23a or 28a-f ehow al Exeminat must be notified at	l by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	<b>s</b> :		1 □ Yes 2	No No	Specify:				Specify: Wh:	ite	
2	natu dical	etec	15. Decedent's Education (Specify only highest grade completed)		16a. Dece (Give	dent's Usual kind of work DO NOT use	Occupa k done d	ition Juring most	t of worki	ng	16b. Kin	d of Business/	Industry	
21215-0036	then.	Completed	Elementary/Secondary (0-12) College (1-4o	r 5+)	Never			,						
2 0	Hygie other ant,		N/A  17. Father's Name (First, Middle, Last)		Nevel	Linpic	Jycu	18. Mothe	r's Name	(First, Middle,	Maiden S	Sumame)		
Maryland	should be littled within 7.2 hours arter death with the maryrat and Mental Hyptishes.  Indexted other than "natural", or items 23a or 28a-1 ehow umatic event, the Medical Examinar must be notified at	To Be	William P. Pantazes					No1a	Ma11	.as				
aZ	es 1 and 2 should by Health and Ment (item 27 le marked rother treumatic e	-	19a. Informant's Name/Relationship (Type, Print)							l Route Numbe				
Σ.	and 2 ealth a n 27 le		Nola Pentazes/ Mother							enn Dal				
	i of H		20a. Method of Disposition 1 🖫 Burial 2 □ Cremation 3 □ Removal from State	20b. P	lace of Dispo emetery, crei arylan	natory or oti d Nat	e of her place i on a			ate		cation - City or	Town, State	
E E	tment tant:		4 □Donation 5 □Other (Specify)		emoria	1 Parl	k	; 1		/2005			1 17	
Bai	permit. Pages I Department of H Important: If ite eny injury or ott		21. Signature of Funeral Service Licensee							ert E. d Bowie			ral Hom	e
			23a. Part1. Enter the disease, or complications that caus	ed the death								20713	Approximate	
	)hyaisian		shock, or heart failure. List only one cause on each Immediate Cause (Final		0 1	C							Onset and I 1 Year	ween Death
	Physician /Medical		disease or condition resulting in death)  Metast  Due to (or a	atic as a consequ		cance	Г						1 ICAI	
	Examiner		Sequentially list conditions, b.											
	9 #	Iner	cause. Enter Underlying	es a dunsaqu	uence of)									
	and and I-trans	Examin	Cause (Disease or injury that initiated events c. resulting in death) Last Due to (or a	as a consequ	uence of):									
760,	ate be executed hysicien and the burial-transit	calE		,										
	ilicate g phys	=	d.									i).		
. Box	death certificat e attending phy id for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth			∃Ectopic pre	ennancy				2	3d. Date of de	•	,
	0 0 0	sicia	in the past 12 months?  1 □ Yes 2 □ No  □ Unknown	at time of d		Other (spe						Month	Day Y	/ear
о. О	The law requires that the de ate hes been signed by the a page 2 should be detached	Phy	9 Unknown  Part II. Other significant conditions contributing to death	hut not res	ulting in the u	nderlying ca	ause aive	n in Part I		23e. Did to	obacco us	se contribute to	the cause of d	leath?
ds,	signed d be del	d by	Tarrin Street Significant contains continuing to death	7 200 1100 100	anny in a co	indonying oo	auso give				∕es 2X		obably 4 🔲	
Records,	w requir been si should	Completed								24a. Was	an	24b Were a	utopsy findings	available
Вě	he iav e hes ige 2	mo								autop perfo	rmed?	prior to death?	completion of ca	ause of
		0	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes		1 ☐ Yes	2 □ No	
⋛		ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☑ Inpa	atient 2	ER/Outpatier	nt 3 DO	A Othe	9r: 4 □ Nu	ırsing Ho	me 5 Resid	dence 6	Other (Spe	cify)	
	ding Ph h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of In (Month, i	njury Da <i>y Year)</i>	28b. Time o Injury		8c. Injury Work			28d. Describe h	now injury	occurred		
sio	r Attending er death. rector: After by the funer	cat	2 Accident investigation	Initiation Addition	4	M		Yes 2 🗌		28f Longtion /	Stroot 2 ac	Alumbos os P	ural Route Num	bac
É	or At after of Direct in by	Certification:	determined 286. Place of	etc. (Specif	ome, farm, st	reet, factory	, office			City or Tox			urai Houte Num	ber,
_	Hospital or Atteno 24 hours after deatl Funeral Director: tely filled in by the		29a. Certifier  (Check only  2 Medical Examiner: On the basis	est of my kno	wledge, deat	h occurred a	at the tim	ne, date an	nd place,	and due to the	cause(s)	and manner as	stated.	
	To the Hospital or within 24 hours after To the Funeral Direction Completely filled in b	edical	(Check only 2 Medical Examiner: On the basis and manner		ition and/or in	vestigation,	in my op	oinion, dea	ith occurr	ed at the time,	date and	place, and due	to the cause(s	)
	Vithi To tl	ž	29b. Signature and title of certifier		/ . A	29c.	. License	number			29d. Date	signed (Mont	h. Day, Year)	
)			Jevin Khann	1	MN.		3829	9			11/1	0/2005		
			30. Name and address of person who completed cause of	of death (Item	n 23a) (Туре, этыгахг (	Print)	Dri	ive S	uite	205 Gr	eenb	elt. MD	20770	
1 4	Sta	ate	31. Date filed (Month. Dav. Year) 32. Refi	strar's Signa										
	Regist		NOV 1 6 2005	and a	K	back								

DHMH 17 Rev 1/2001

ORIGINAL

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	F F D	un ire	er: cto	al or
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Department of result and mental hygiene. Important: If Item 27 is marked other then "natural", or Itema 23a or 28e-f show	any injury or other traumatic event, the Medical Examinar must be notified at	once.

			1 - State Registrar			Cei	rtifica	te of	Death	7	R	eg. No.	00	0 3/1 2/0
	- N		1. Decedent's Name (First, Middle, La	st)							2. Date of Deat	th 12	2	3. Time of Death
-	Physici		Carl Raymond Pet	erson							Month Novembe			11:45P M
	/Medi Examir		4a. Facility Name (If not institution, giv		ər)		4b. City	y, Town,	or Location	of Death		1	ounty of Death	
	LAGITIII		Holy Cross Hosp	tal			Sil	lvor	Sprin	200		Mc	ntgome	<b>617</b>
	Funeral		5. Social Security Number 6.5		Age (In yrs.	last birthday)	If Unde	er 1 Year	If Under		8. Date of Birth (Month, Day,		9. Birthp	lace (State or Foreign
	Director		021-12-6448	MM 2□F	83	Yrs.	Months	Days	Hours	Min.	Jan. 4	192	22 Massa	chusetts
46	D		Usual Residence of Decedent							1				
	ylan		10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation						1	0d. Inside City Limits
	Ma B-f	tor	Maryland Montgor	nery		Silve	er Sp	pring	ı					1 ☐ Yes 2N☐ No
	or 28	Directo	10e. Street and Number				10f. Z	ip Code			1	0g. Citize	n of What Cour	ntry?
	h wil		10158 Sutherland	Road				2090	)1			US	SA	
	72 hours after death with the Maryland natural', or Itema 23a or 28e-f ehow Jical Examinat cust te notified at	Funeral	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	J.S. 13.	Was Dec	edent of	Hispanic Or	rigin? (Spec	ify Yes or No-	14	. Race - Americ Black, White,	
9	after or Ite		1 ☐ Never Married 2K Married	1 X Yes 2 [ If Yes, Give			1 □ Yes				ilcari, etc.)			
8	ral',	t by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s: WWI	Ι	1 🗀 103	2 <b>X</b> 1 140	эрвспу			3,	pecify: Whit	ce
20	i within 72 ho jiene. r then "natui tre Medical	Completed	15. Decedent's E	ducation ade completed)		16a. Dece	dent's Us	ual Occu	pation during mos	st of workin	a	16b. Kind	of Business/In	dustry
7	within ene. then	npie	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT	use retire	nd)					
21		So		4		Mec	hani	cal	Engin				S. Navy	<i>r</i>
g	0 = 0 \$	e	17. Father's Name (First, Middle, Last						18. Moth	er's Name	(First, Middle, M	Maiden Si	umame)	
<u>a</u>	Menta Menta arked atic ev	To	Harry Peter Pete						Ene	z Joh	anna Li	ndst	rom	
Maryland 21215-0036	2 sho and 1 ie ma		19a. Informant's Name/Relationship		ife		-						Town, State, Zip	
	and alth		Emma Pauline Pet	erson/ <del>W</del>	iofe-	1015	8 Su	ther	land	Road,	Silver	Spr	ing, MD	20901
altimore,	rmit. Pages 1 and 2 should be partment of Health and Menta portant: If Item 27 is marked by injury or other traumatic evice.		20a. Method of Disposition	3D		Place of Dispo	sition (Namatory or	ame of other pla	ice)	Novembe Novembe			tion - City or To	
Ĕ	Page III		ty∷ Burial 2 ☐ Cremation 3 § 4 ☐ Donation 5 ☐ Other (Special		10 [	throp Fr				2005	-		Caroli	
Ħ	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	isee D	20	24	rane	and Addy	ess of Facil	"Yins	Funeral	Hom	e Inc	
ä	F 0 F 0		Willia	- I B	nel	5	00 U	nive	rsity	Blvd	, W, Si	lver	Spring	, MD 20901
	200		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cade	ed the deal	th. Do not ent	er the mo	ode of dy	ng, such as	s cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final											Onset and Death
	/Medical		disease or condition resulting in death)	a. Sepsis	as a consec	Thence of):								6 Hours
	Examiner			240 10 (0.		400.100 01).								
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consec	quence of):								
	uted d ansit	E	Cause (Disease or injury that initiated events											
Ć,	be execute sician and burial-trans	Examin	resulting in death) Last	Due to (or	as a consec	quence of):								
292	e be sicia e bur			d										
68760,	certificate be executed ding physician and ise as the burial-transit	/Medical										-		
Xo			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			<b>-</b>					236	d. Date of delive	ery
m	death a atten	Physicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant			JEctopic Other (s		y				Month	Day Year
0.0	that the de	ys	9 Unknown	9∐ Unknowr	1									
	that thed to det	by P	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying	cause gi	ven in Part	I.	23e. Did tot	oacco use	contribute to the	ne cause of death?
ds	tuires n sign ald be	d b	Respiratory Fail	ure, Atri	al Fi	brilla	tion	,			1 ☐ Ye	s 2 🗆	No 3□ Prob	ably 4X Unknown
S	law requires that the death as been signed by the atte 2 should be detached for	Completed	Alzheimer's Deme	ntia							24a. Was a	n :	24b. Were auto	psy findings available
Be	0 5 0	E									autops perform	y	prior to co death?	mpletion of cause of
of Vital Records,	ian: Thi rtificate stor, pag	e C	OS Man anna referred to modical									Ø⊡ No	1 🗆 Yes	2 No
⋚	.∺ 8 €	o Be	25. Was case referred to medical examiner?	Hospital:		75000		ot Ot			(Check only on		70. 10	
o	Phys ral di	$\vdash$	1 Yes 2 No 27. Manner of Death	28a. Date of I		ER/Outpatier 28b. Time o		200	4 🗀 14		e 5 Heside 3d. Describe ho		Other (Specif	y)
n	ding I h. After funer	lon	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	м	28c. Inju Wo	irk? ]Yes 2.[			,, .		
<u>S</u>	Attending in death. ector: After by the fune	ica	3 Suicide 6 Could not b	e One Diese of	Iniuny . At h	nome farm str					Bf Location (St	reet and t	Number or Rura	I Route Number.
Division	or Atten after deat Director:	Certification:	4 Homicide determined		etc. (Special		Jos, racio	.,,, 0,1100		-	City or Town	, State)		
_	To the Hospital or within 24 hours after To the Funerel Directon pletely filled in E		29a Gertiffer 1/X Certifying Pt	rysician: To the be	ar of this be-	reduction stoom	h consumer	A or He in	ima itata s	and otherwise are	et qua los les as	Nicosofiel ex	al manismin e	rat of
	24 h Fun Fun	Medical		niner: On the basis	s of examina									
	thin ithin or the symple	Me	29b. Signapare and title of certifier	and mainler	Jaiou.		2:	9c. Licen	se number		2	9d. Date :	signed (Month,	Day, Year)
	⊬ ≱ ⊨ 8		No.					D28	8656				mber 15	
			20 North	completed cause of	d death for	- 02a) CT :	Deign							,

State Registrar

Ravi Passi, M.D. 31. Date filed (Month, Day, Year) NOV 1 7 2005

32. Segistrar's Signature

15225 Shady Grove Road, #208, Rockville, Maryland

		•	1 - For State Registrar	State of M	larylan		artment rtificate			and M		giene	005	39199
	Physici	_	1. Decedent's Name (First, Middle, L Anna S. Porte								2. Date of Dea Month November	er 9,	2005	3. Time of Death 8:45 P. M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number	)		4b. City, To	own, or i	Location o				ounty of Deat	h
, Sept.		1	Asbury Solomons	Health Car	ce Cer	nter	Solom	ons	14 (11 24 - 14	2411		Ca	lvert	
	Funeral Director		5. Social Security Number 6. 005–20–8521  Usual Residence of Decedent		ge (In yrs. 1 79	Yrs.	If Under 1 Months	Days	Hours	Min.	8. Date of Birt (Month, Day Sept 2	7 <sup>7</sup> °°f′92	9. Birti	hplace (State or Foreign untry) NE
	/land		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	a-f sh	ctor	Maryland Calver	t	S	olomon	s							1 ☐ Yes 2 ☐ No
	th with th	ai Dìre	10e. Street and Number 510 Aldersgate C	ourt 514			10f. Zip C	ode 588				-	en of What Co ed Sta	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural; or itema 23a or 28a-f show any futury or other traumatic event, the Medical Exerting mast is notified at anothe.	i by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Tyes 2 Tif Yes, Give Year or Dates:	?_		Was Decede f Yes, specifi 1  Yes 2	y Cuban	panic Orig , Mexican Specify:	jin? (Spe , Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, White pecify: Wh	
21215-0036	ithin 72 ho ne. "natu	Completed	15. Decedent's (Specify only highest g	rade completed) College (1-4or	5+)	(Give life. i	ient's Usual kind of work DO NOT use	doné du retired)	tion uring most	of worki	ng		of Business/I	
22	Hygier Hygier ther ti nt, in	Col	17. Father's Name (First, Middle, Las	4 st)		hom	emakei		18. Mothe	r's Name	(First, Middle,		n home	
and	should be find Mental Himarked of	To Be	Charles Bean	,,,					Alma			Walder St	amamo)	
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship			19b. Mailir	g Address (	Street ar	nd Numbe	r or Rura	I Route Numbe	r, City or 1	own, State, Z	lip Code)
	and 2 ealth a m 27 is		John D. Porter-	husband			مخاط المانشيطانات			iii	Solomo			<u>.</u>
Baltimore,	Pages 1 nent of H ant: If Ita ury or otl		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Spec		C	lace of Dispo emetery, crer ropoli	natory or oth tan Fu	er place iner	ur D	A T		lexa		Virginia
Balt	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Lic	ensee		44	Name and	Address	of Facility  Island	Rau Road	sch Fun d, Port R	eral zubli	Home, c. Maryl	P.A. and 20676
1	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or co-shock, or heart failure. List only mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to infinite dialogause. Enter Underlying	mplications that cause yone cause on each  a. CFRF  Due to (or a:	line. Be 3 V s a consequ	uence of):						rest,		Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	cause, Disease or injury that initiated events resulting in death) Last	c.  Due to (or as	s a consequ	uence of):								
.O. Box 68	Attending Physician: The law requires that the death certifica robath. sctor: Atter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic preg Other (spec					236	d. Date of deli Month	very Day Year
rds, P	quires that in signed b uld be dett		Part II. Other significant conditions  FHELMATOLD	contributing to death		ulting in the u	nderlying cau	ise giver	n in Part I.		23e. Did to			the cause of death?
Vital Records,	The law recate has bee page 2 sho	Completed by									24a. Was a autop perfor	sy	prior to o death?	topsy findings available ompletion of cause of
Vita Vita	ician certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:				Other		-	(Check only or			
Division of	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Inj (Month, Da	ury	ER/Outpatien 28b. Time of Injury		: Injury	at	2	ne 5 Resid 28d. Describe h			ify)
Divis	al or Atter after dea I Director d in by the	Certification:	3 Suicide 6 Could not determine	d 289. Place of in	njury - At ho	ome, farm, str	eet, factory,	office		2	28f. Location (S City or Tow		Number or Ru	ral Route Number,
	To the Hospital or within 24 hours after To the Funerel Director Completely filled in I	Medical C	29a. Certifier 1 ☐ Certifying F (Check only 2 ☐ Medical Ext	Physician: To the besi aminer: On the basis and manner s	of examinat	wledge, death tion and/or in	occurred at restigation, in	the time	, date and nion, deat	d place, a	and due to the co	ause(s) ar late and pl	nd manner as ace, and due	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	Λ				License					signed (Month	
)			Mes	elan			0	76	318		,	Nol	1.10.	2005
	ID		30. Name and ad ss of person	100	•		*							
9	JO Sta	te.	John H. Weigel, 31. Date filed (Month, Day, Year)	MD 110 Hos 32. Regist	pital s Signal	Road,	Suite	e 31	0, PI	rince	e_Frede:	rick,	MD 206	78
	Registr		NOV 1	32. Regist	Uneva.	, K	Spark	م						

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland	Depa / Depa	rtment of H	ealth and Death		giene Reg. No.	105	39200
			Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici		MARTHA LEONA SCHM	IAELING				Month Novemi	Day	Year 4. 2005	11:30 p <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or	Location of D			ounty of Death	11.50 p
			Hillhaven Nursing	Home		Adelphi			Pr	ince Geo	rge!e
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Bin	th		lace (State or Foreign
	Director		215-68-7687	м 2)ДГ 92	Yrs.	Months Days	Houis	April 2			necticut
	pu >		Usual Residence of Decedent  10a. State 10b. County	10c, City, T							
	anyla shov	-	,	,		ation				"	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ne M	Director	Maryland Prince Ge	orge's Adelp	hi	1.01.71.0.1					
	with t		10e. Street and Number		_	10f. Zip Code			-	n of What Coun	ntry?
	sath	eral	3210 Powder Mill R	oad - Apt. #15.  2. Was Decedent Ever in U.S.		20783	capio Origin?	/Specify Vec or No	U.S.A	. Race - America	an Indian
	Item Item	Funeral	1 Never Married 2 Married	Armed Forces?  1  Yes 2  No	lf.	Yes, specify Cubar	n, Mexican, Pu	? (Specify Yes or No uerto Rican, etc.)		Black, White,	
39	ursaf eli, or ats⊞	by F	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Sį	pecify: Whi	.te
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. Ither than "naturel", or Items 23e or 28e-f show ent. It e Macifical Exactiner must be notified at	ted	15. Decedent's Educ	ation 1	6a. Deced	ent's Usual Occupa	ition		16b. Kind	of Business/Ind	dustry
72	hin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give I life. E	kind of work done d O NOT use retired,	luring most of )	working			
7	d with giene er the	mo;	Cidition tary/odcorroary (O 12)		Regis	tered Nu	rse		Hosp	oital	
b	e file al Hyj othe vent.	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,			
<u>a</u>	denta Aenta rrked tic e	To E	Fred R. Alford				Lizzie	e Mabel Cr	aft		
a	and land		19a. Informant's Name/Relationship (Typ	e, Print) Husband	19b. Mailin	g Address (Street a	nd Number or	Rural Route Numbe	er, City or T	own, State, Zip	Code)
Σ	bs 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Merial Hygiene. If mealth and Merial Hygiene is not litems 23e or 28e-1 show it item 27 is marked other then "neturel"; or items 23e or 28e-1 show rother treumetic event. It e Madical Exertirer must be notified at		Chester A. Schmae				.11 Roa	d #155, A	delph:	i, MD 20	0783
ore	of He of He fiten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	come	e of Dispos etery, crem	sition (Name of atory or other place	9)	Date	20c. Loca	tion - City or To	wn, State
altimore,	permit. Pages Department of h Importent: If ite eny injury or of once.		'4 □Donation 5 □ Other (Specify)		etera	ns Cemete	ery   11/	21/2005	Chelt	enham.	Marvland
ä	porting y injusting		21. Signature of Funeral Service License		22.	Name and Addres	s of Facility	Gasch's F	unera	1 Home,	P.A.
m —	89 = 9	. 11-1	Ben L. achees		47	39 Baltin	nore Av	e., Hyatt	svill	e, MD 2	0781
П			23a. Pan1. Enter the disease, or complice strock, or heart failure. List only one	ations that caused the death. De cause on each line.	o not ente	r the mode of dying	g, such as card	diac or respiratory ar	rest,		Approximate Interval Between
d	Fnysician	( u	Immediate Cause (Final dise ise or condition	Alzheimer's D	iseas	ρ					Onset and Death
	/Medical		resulting in death)	Due to (or as a consequent							
	Examiner	,	Sequentially list conditions, b.								
	p = 0	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequent	ce of):					7.1	
	and -trans	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence	on of):						
8760,	cate be executed physician and the burial-transit			Due to tot as a consequent	ce or).						
	cate phys	dical	d.	<del></del>							
×	death certifi e attending p id for use as	Ψ	IF FEMALE:	c. If yes, outcome of pregnancy					20	d D-44 d-15	
Вох	atten for us	Physician/M	in the past 12 months?	1 Live birth 2 Fetal death	ath 3 🗆	Ectopic pregnancy Other (specify)			230	<ul> <li>d. Date of deliver</li> <li>Month</li> </ul>	ry Day Year
o.	at the de by the a tached	ysic	1 ☐ Yes 2 X No 9 ☐ Unknown	9 Unknown	. 30	Otter (specify)					
a.	that the by detact	/ Ph	Part II. Other significant conditions cont	ributing to death but not resultin	g in the un	derlying cause give	n in Part I.	23e. Did to	bacco use	contribute to the	e cause of death?
Records,	88	d by						101	res 2∭X	No 3 ☐ Proba	ably 4 Unknown
Ö	w require been si should?	ete						24a. Was	20 0	74h Wore outer	ou findings qualishle
Re	: The law cate has t page 2 s	Completed						<ul><li>autop</li></ul>	rmed?	prior to con death?	osy findings available npletion of cause of
			or Western day and incl					1 ☐ Yes	2 🕅 No	1 Yes	2 🗆 No
<u> </u>	sicie	o Be	25. Was case referred to medical examiner?	ospital:				Death (Check only o			
ō	Phys r this ral di	$\vdash$	1 ☐ Yes 2 No  27. Manner of Death	1 Inpatient 2 EH/	Outpatient b. Time of	3∐ DOA 28c. Injury	4 V Nursin	g Home 5 🗋 Resid			)
0	ding h. h. After funer	tion	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work	? ′es 2. □ No				
Division of Vital	Hospitel or Attending Physicien: 44 hours alter death: Funerel Director: After this certificately filled in by the funeral director, tely filled in by the funeral director,	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home	, farm, stre	et, factory, office		28f. Location (S	Street and N	Number or Rural	Route Number.
2	after Direction by	erti	4 Homicide	building, etc. (Specify)				City or Tow	n, State)		
	ospitel hours unerel		29a. Certifier 1∑ Certifying Physi	cian: To the best of my knowled	dge, death	occurred at the time	e, date and pla	ace, and due to the	cause(s) an	id manner as sta	ated.
	To the Hos within 24 ha To the Fun completely	edical	(Check only 2 Medical Examin one)	er: On the basis of examination and manner stated.	and/or inv	estigation, in my op	inion, death o	ccurred at the time,	date and pla	ace, and due to	the cause(s)
	To the vithin 2 To the complet	Me	29b. Signature and title of certifier	1		29c. License	number		29d. Date s	signed (Month, D	Day, Year)
			Muchal 1	Hard a	1	D2628	37		Novem	mber 15,	2005
1	16)		30. Name and address of person who con	npleted cause of death (Item 23)	a) (Type, F						
	6		Michael Berard, M.	D. 7305 Balts	imore	Boulevar	d, Sui	te 107, C	olleg	e Park,	MD 20740
	Sta	te	31. Date filed (Month, Day, Year)	■ Registrar's Signature							
	Registr	ar ·	NOV 1 8 2005	Beaux &	Z	151					

			1 - For State Registrar	State of	Maryland		artmen rtificat				_	giene	nni	5	3920	) [
	Physici	an	1. Decedent's Name (First, Midd.	le, Last)							2. Date of De Month	ath Day	, Y	ear	3. Time of D	eath
	/Medic			Minette		Α.		ulliv			November	17,	2005		9:10 p	M
	Examir	ier	4a. Facility Name (If not institution 1712 Glenkarney F	. 3	oer)				Location o	of Death			County of			
	Funeral		5. Social Security Number		. Age (In yrs. las	t birthday)		er Sp	ring If Under	24 Hrs.	8. Date of Bir	+h	ntgome		lace (State or i	Foreian
	Director		449-05-0604	1 ☐ M 2 🖾 F	94	Yrs.	Months	Days	Hours	Min.	Dec. 28,	1910 1910		Coun	Texas	g
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Lo	eation								Od. Inside City	I i mais .
	Aaryla f sho	ច												'	1 ∐ Yes ‡	
	28a-	Director	Maryland Montgo  10e. Street and Number	nery	211	ver Sp	rang 10f. Zip	Code				10g. Citi	zen of Wha	at Coun	trv?	
	72 hours after death with the Maryland natural; or Itams 23a or 28a-1 show ideal Exantiner must be notified at		1712 Glenkarney	Place				2090	2			US	SA		•	
	ams ams	Funeral	11. Marital Status	12. Was Deced Amed Force	ent Ever in U.S. es?	13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)		14. Race - Black,			
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	ried 1 ☐ Yes 2	XXNo		1 □ Yes 2		Specify:		, , , , , , , , , , , , , , , , , , , ,		Specify:		uite	
8	tural			Year or Date		16a. Deced	dent's Usua	I Occupa	tion			16h Ki	nd of Busir			
215	⊆ 9	plet		st grade completed)  College (1-4		(Give	kind of wor DO NOT us	k done d	urina mosi	t of worki	ng	100.70	110 01 0001	1033/1110	Justiy	
21	filed with Hygiene. Other than	Completed	z.omornary, obcornary (b 12)	4			Homema	aker					In Hon	ne		
ind	ed ita	Be	17. Father's Name (First, Middle,						18. Mothe		(First, Middle,	, Maiden	Sumame)			
Maryland 21215-0036	d 2 should be th and Mental 7 is marked o traumatic eve	၉	Julius Alexan			10b Mailie	a Addroso	(Stroot o	and Missania		Pizer	Cit	. Ta Ott	7:-	0-4-1	
Ma	ロモトセ		Belinda Engels / L												Code)	
re,	一千萬五		20a. Method of Disposition	Ü	cam	e of Dispo	sition (Nam natory or o	ne of			ille, Man		cation - Cit		wn, State	
E			1XXBurial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (S		ate _	rectio	on Ceme	etery	11	1/22/:		Clint	on, Ma	ryla	ınd	
Baltimore,	permit. Page Department Important: If any injury of once.		21. Signatur of Funeral Service	Licensee		22	. Name an	d Addres	s of Facilit	y Georg	e P. Kala	as Fin	neral I	Home	Ъ	
	g 0 = g 9		fly ".	Res			OTOD O	хон п		au ux	on Hill,	Pary.	land	2074	Ŋ	
			23a. Party. Enfer the disease, o shock, or heart failure. List Immediate Cause (Final	r complications that can only one cause on eac	the death. In the line.						r respiratory ai	rrest,			Approximate Interval Betwe Onset and De	en ath
F	Fnysician /Medical		disease or condition resulting in death)	a. Due to (a)	17		144	141	01/17	-						
	Examiner			Due to (or	as a consequer	ice or):										
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Oue to (or	as a sonsequen	ica otj:										
	ecuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									_	_		
8760,	icate be executed physician and s the burial-transit		resulting in death) cast	Due to (or	as a consequen	nce of):										
687	death certificate be executed e attending physician and ad for use as the burial-transit	dical		d										-		
Box (	death certific attending pl	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnancy	у						2		f delive	īv	
Ö.	ne death the atte	sicia	in the past 12 months? 1 Yes 2XXNo	4□Pregnar	h 2 ☐ Fetal de nt at time of deat		Ectopic pro Other (spe						Month		Day Yea	ar
P.O.	= > 0	Phys	9 🗆 Unknown	9□ Unknow												
Records,	n requires that been signed b should be deta	by	Part II. Other significant conditi	ANEMI	th but not resultin	ng in the ur	nderlying ca	iuse give	n in Part I.		23e. Did to	1			e cause of dea ubly 4 □Unk	
ecc	aw as b	Completed									24a. Was autop	SV	24b. Wer	e autop	sy findings ava	ailable se of
E E	Tr ate pa	Con									perfo	rmed?	deat	h?	2 🗆 No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check on o					
oĮ	Phys or this oral di	To I	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of	atient 2□ER Injury 28	Outpatien  Time of		A Bc. Injury Work	4 🗀 1901		ne XX Resid			Specify,	)	-
ion	Attanding Phirderships of the funeral of the funera	atlor	XX Natural 5 ☐ Pendir 2 ☐ Accident investi	9	Day Year)	Injury	М		? es 2 □ N	No						
Division	or Attano after death Director: in by the	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	lined 286. Place of	Injury - At home , etc. (Specify)	, farm, stre	eet, factory	office		2	8f. Location (S City or Ton	Street and	<i>Number</i> o	r Rural	Route Number	r,
	ital or urs afte ral Dire		<u> </u>										<u> </u>			1
	To tha Hospital or At within 24 hours after d To tha Funaral Direct completely filled in by	edical	29a. Certifier 1 ☑ Certifyii (Check only one)	ng Physician: To the be Exeminer: On the bas and manne	is of examination	dge, death and/or inv	occurred a restigation,	in my opi	e, date and inion, deat	d place, a h occurre	nd due to the o	cause(s) a date and	and manne place, and	r as sta due to	ited. the cause(s)	
	To tha h within 2- To tha h complete	Σ	29b. Signature and title of certifie	0000001			29c.	License	number		0		signed (N			
^	(10)		7.00	while	- my	>		D	+ 4	21	8	Novemi	ber 18	, 200	05	
R	(10)		30. Name and address of person  Gul Chablani M	who completed cause of the second sec				kwi11	e Mar	no lar	20852					
	Sta	te	31. Date filed (Month, Day, Year)					IV A TTT.	C PELL	утано	20032					
	Registr	ar	NOV 1 8 2	005	istrar's Signature	6704	2									

			State of Maryland / Department of Health  1 - State Registrar  State of Maryland / Department of Health  Certificate of Death	_	giene 05	39202
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last)  VICTORIA  O SAWYERR-WATSON  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location	2. Date of Do Month NOVEMBE	Day Yea	
	Funeral Director	ei	3255 NORMANDY WOODS DRIVE #D ELLICOTT CITY  5. Social Security Number 218-23-2123  6. Sex 1 Months Days Hours 7. Age (In yrs. last birthday) Months Days Hours	7	HOWARD  th Year) 6 1954 SIE	tirthplace (State or Foreign County) LRRA LEONE
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Markleal Examiner must be notified at	ector	Usual Residence of Decedent   10a. State   10b. County   10c. City, Town or Location   MD   HOWARD   ELLICOTT CITY   10a. Street and Number   10f. Zip Code		10g. Citizen of What	10d. Inside City Limits Yayes 2 No
	sath with t	Funeral Director	3255 NORMANDY WOODS DRIVE #D 21043	Arinin2 (Specify Vac or N	USA	nerican Indian,
900	ours after de ral', or Item Examiner	by	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		Specify	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, if the Modical Examinet must be notified at Once.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12th  15a. Decedent's Usual Occupation (Give kind of work done during modified DO NOT use retired)  SECRETARY SUPERVI		16b. Kind of Busines	ss/Industry
Maryland 2	ould be filed Mental Hyg arked othe atic event,	To Be C	OLU D. SAWYERR HAN	her's Name <i>(First, Middle</i> NNAH M. RENN	IER	
	and 2 shi alth and 27 Is m er traum		19a. Informant's Name/Relationship ( <i>Type, Print</i> )  WINIFRED K. WALKER/DAUGHTER  1320 HAMPSHIRE DRI			
Baltimore,	Pages 1 nent of He ant: If iten ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name of cemetary, crematory or other place)  GEORGE WASHINGTON	Date 11/26/2005	ADELPHI,	
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facil 7474 LANDOVER I		KINS FUNERA ER,MARYLANI	
	Pnysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition SEVERE HYPERTENSION resulting in death)	as cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
	/Medical Examiner	Iner	HYPERTENSION HEART DISEASE			
8760,	death certificate be executed attending physician and of for use as the burial-transit	ilcal Examiner	d.			
.O. Box 6	death certifi e attending ed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of o	delivery Day Year
rds, P	es Deg	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		tobacco use contribute Yes 2∭No 3□	to the cause of death?  Probably 4 □Unknown
Il Records,	The ate h	Completed	RENAL FAILURE	24a. Was auto peri 1 □ Yes	s an 24b. Were prior to death 2 No 1 1 Y	
on of Vital	Attending Physician: Thr death. sctor: Atter this certificate by the funeral director, pag	stlon: To Be	examiner?  1  Yes 2 No			pecify)
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or wn, State)	Rural Route Number,
	To the Hospital or within 24 hours affer To the Funeral Dircompletely filled in	dicalC	29a. Certifier  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date an (Check only one)  2 Medical Examiner: On the basis of examination and/ar investigation, in my opinion, dean manner stated.			
}	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number  1. D13671	r	29d. Date signed (Ma	
R	(5)		30. Name and address of person who compleme cause of leath (Item 23a) (Type, Print)  B.G. MANEJWALA MD, 14201 LAUREL PARK DRIVE #102 LA	UREL MD 20		
	Sta Regist		31. Date filed (Month, Day, Year)			

		1 - State of Ma	ryland / Depa <i>Cen</i>	rtment of He tificate of D			2005	39203
		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
Physic		Florine Skipwith					14 2005	2:05 P M
/Med Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
Exaim		907 Flores St.		Sea	t Pleasar	nt	Prince	George's
Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	nplace (State or Foreign untry)
Director		579-26-4440 1□M 2\\ F	80 Yrs.	Widness Bayo	110010	May 13,	1925 Wa	sh., DC
PL ,		Usual Residence of Decedent	10c. City, Town or Loc	notice				10d. Inside City Limits
anylar show			Toc. City, Town of Loc		Pleasant	F		1 ☐XYes 2 ☐ No
Ba-f	cto	Maryland Prince George's			Tieasani			
or 2	Director	10e. Street and Number		10f. Zip Code		100	. Citizen of What Co	
ath w		907 Flores St.		<u></u>	20743	" "		States
be filed within 72 hours after death with the Maryland tal Hygiene. I other than "natural", or Items 23a or 28a-1 show event. If we Medical Ever invest national and the recities of the state of the st	by Funeral	11. Marital Status  12. Was Decedent E Armed Forces?		Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes of No- Rican, etc.)	14. Race - Ame Black, White	
s afte	Y.	1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No H Yes, Give 1 □ Yes con Dates:	1	□Yes 2□XNo	Specify:		Specify: B	lack
tural		15. Decedent's Education	16a Deced	ent's Usual Occupa	tion	16	bb. Kind of Business/	Industry
of a should be filed within 72 hours at the and Mental Hygiene. It is marked other than "natural", or traumatic event. It a Medical Entrains	Completed	(Specify only highest grade completed)	(Give F	kind of work done di OO NOT use retired)	uring most of worki			
withi ene. than	mg	Elementary/Secondary (0-12) College (1-4or 5-1)	-)	Sune	rvisor		GSA - G	overnment
filed Hygir	Ö	17. Father's Name (First, Middle, Last)		Баре		e (First, Middle, Ma		0 1 0 1 1 1 1 1 1
0 7 5	Be C	Ignatius Jones				Mary Sh	dreama	
should be and Mental smarked umatic ev	ပ္	19a. Informant's Name/Relationship (Type, Print)	19b. Mailine	g Address (Street a	and Number or Rura		City or Town, State, 2	Tip Code)
d 2 s d 2 s th an th an trau	100	Gail Robinson/Daughter		Jacob's				144
T and 1 and Health em 27 sther tr		20a. Method of Disposition	20b. Place of Dispos	sition (Name of	.   .	Date 20	c. Location - City or	Town, State
Pages nent of ont: If it		1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State	Resurrect		II	8/2005	Clinton	MD
Definition of the popular of the pop	1 3	. 4 ☐Donation 5 ☐ Other (Specify)  21. Signa re of Funeral Service Licenses		Name and Addres			neral Hom	
permit. Pages 1 and 2 should b Department of Health and Menta Importent: If item 27 is marked any injury or other traumatic enones.		Noun T. Slavers	II	4001 Be	nning Rd	., N.E. W	Wash., DC	
		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not ente e.	er the mode of dying	g, such as cardiac c	or respiratory arres	t,	Approximate Interval Between Onset and Death
Fhysician		Immediate Cause (Final	creatic Car					Onset and Death
/Medica	_	resulting in death)	consequence of):					
Examine		Sequentially list conditions, b.						
D =	ner	if any, leading to immediate Due to (or as a cause. Enter Underlying	consequence of):					
cuter	Examine	that initiated events c.						
e exe ian a urial-		resulting in death) Last Due to (or as a	consequence of):					
cate be executed physician and the burial-transit	dicai	d						
as ∰ E	Med	IF FEMALE:					1	
eath certifi attending I	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy			23d. Date of del	ivery Day Year
the death cer y the attendic sched for use	Sici	1 Yes 2 No 9 Unknown	time of death 5	Other (specify)		<del></del>		22,
that the de led by the a detached f	J.	9 Unknown			i Book	00a Did taha	cco use contribute to	the equal of death?
D, T	þ	Part II. Other significant conditions contributing to death but Malnutrition	t not resulting in the ur	ideriying cause give	in in Part I.		77	obably 4 Unknown
w requir been si should	ted					1 103	20140 0011	obably 4 Donklown
vical necolus, sicien: The law requires t certificate has been signe irector, page 2 should be v	Completed	Hepatic Encephalopath	У			24a. Was an autopsy	24b. Were au prior to d	topsy findings available completion of cause of
The I	E C					performe 1 ☐ Yes 20	ed? death? ☑No 1 ☐ Yes	2□ No
VICION: The certificate rector, pag	e)	25. Was case referred to medical			26. Place of Death	h (Check only one)		
_ > S D	ToB	examiner? 1 ☐ Yes 2 ☐ Yo Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatien	t 3 DOA Othe	4 ☐ Nursing Ho	me 5 residen	ce 6 □Other (Spec	cify)
Mision of what Attending Physicien: It death. ector: After this certific by the funeral director,		27. Manner of Death 1X Natural 5 □ Pending 28a. Date of Injur (Month, Day	y 28b. Time of Injury	28c. Injury Work	at c?	28d. Describe how	injury occurred	
Low Attending Physalter death.  Director: After this in by the funeral di	atic	2 Accident investigation		M 1 1 1	Yes 2□No			
or Attendate death Director:	iii iii	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	ry - At home, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
tel or rs afte el Dir	Certification;							
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	29a. Certifier  (Check only one)  Sertifying Physician: To the best of the decidence of the	examination and/or inv					
To the within 2 To the complet	Med	one) and manner sta  29b. Signature and title of certifier	ieu.	29c. License	number	290	d. Date signed (Monti	h, Day, Year)
Twit Too		M			D0052865			17, 2005
		1. 1 whose figo			C007C000		November	17, 2003
R(3)		30. Name and address of person who completed cause of de K. Michael Figaro, M.D.		<sub>Print)</sub> isinberry	Way Boy	wie. MD	20720	
1					,,,,,			
Regis	tate strar	NOV 2-1 2005	r's Signature	E CONTRACTOR OF THE SECOND				

DHMH 17 Rev 1/2001

Registrar

NOV 2 1 2005

			State of Maryland / Dep State of Maryland / Dep Pegistrar AACO HEALTH DEPT. 11/16/05 CMH Co	partment of Health and Men ertificate of Death	ntal Hygie Reg.		39205
	Dhuaisi		1. Decedent's Name (First, Middle, Last)	2.1	Date of Death		3. Time of Death
+	Physici /Medio		Hillyer Seaborn Smith,	Jr. No	vember	6 2005	10:45 a <sup>M</sup>
1	Examir	er	4a. Fecility Name (If not institution, give street and number) 710 Peggy Stewart Court	4b. City, Town, or Location of Death  Davidsonville		4c. County of Death Anne Arun	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	If Under 1 Year   If Under 24 Hrs   9	Date of Birth	0.0:41	place (State or Foreign
	Director		258-28-1593 XXM 2□F 82 Yrs.	Months Days Hours Min. Ja	Month, Day, Ye $n \cdot 22, 1$	.923 Geo	rgia
	land ow		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limits
	Many P-f sh	tor	MD Anne Arundel Davidso	onville			1 ☐ Yes 2x ZvNo
	or 28	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	a 23a	ıral	710 Peggy Stewart Court	21035		USA	
920	72 hours after death with the Maryland "natural, or itama 23a or 28a-f show sidinal Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Ammed Forces?  1 ☒ Yes 2 □ No If Yes, Give Year or Dates: WWII	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rica  1 ☐ Yes 2 🌠 No Specify:	Yes or No- n, etc.)	14. Race - Ameri Black, White Specify: Wh	, etc.
2-0	72 hor	eted	15. Decedent's Education 16a. Dec	edent's Usual Occupation e kind of work done during most of working	168	o. Kind of Business/Ir	ndustry
121		Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)			
d 2	e filed v if Hygie other t		17. Father's Name (First, Middle, Last)	ultant  18. Mother's Name (Fir		elecommun:	ications
<u>lan</u>	should be nd Mental marked c	To Be	Hillyer Seaborn Smith, Sr.	Alice Wat		on damane,	
Maryland 21215-0036	and Mais mari	8	19a. Informant's Name/Relationship (Type, Print) 19b. Mai	ing Address (Street and Number or Rural Ro		ity or Town, State, Zi	p Code)
6, ₹	is 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than other traumatic avant, the Me		Patricia A. Smith (Wife) 710  20a. Method of Disposition 20b. Place of Disp	Peggy Stewart Court,			
altimore,	permit. Pages Department of I Important: If its any injury or of		4 Donation 5 Other (Specify) Lakemont	osition (Name of pate)  Mem. Gdns 11-10-2	2005 Da	:. Location - City or T avidsonvi]	,
Ball	permit Depart Import any in		21. Signature of Funeral Service Ucansee	22. Name and Address of Facility Hardesty Funeral Ho 12 Ridgely Avenue,	me, P.A Annapol	is. MD 21	401
П			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or res	piratory arrest,		Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. CANCEY of	esophagus and	t sto	mach o	Onset and Death  NE YEAY
	Examiner		-A1/A	1 9			/
	TO ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	icate be executed physicien and s the burial-transit	Examiner	that initiated events				
68760,	icate be execu physicien and s the burial-trar	al E	Due to (or as a consequence of):				
687	g physas the	edical	d				
Вох	death certil e attending of for use a	an/M	IF FEMALE: 23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delive	ery
P.O. E	thet the death cer ed by the attendir detached for use	Physician/M	in the bast 12 months?	Other (specify)		Month	Day Year
	law requires thet the as been signed by th 2 should be detache	by Ph	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	he cause of death?
Vital Records,	w requires t been signe should be	ed b	None		1 ☐ Yes	2No 3☐Prob	oably 4 Unknown
ecc	e law re has be je 2 sho	Completed			24a. Was an autopsy	24b. Were auto	opsy findings available impletion of cause of
<u>=</u>	ysician: The is certificete hadirector, page				performed	? death? No 1 ☐ Yes	20.8 -1
	sician: Th certificete rector, pag	o Be	25. Was case referred to medical examiner?  1   Yes   2   No	26. Place of Death Ch	eck only one)	100000	
o c	or Attanding Physician: ifter death. Director: After this certific in by the funeral director.	n; To	27. Manner of Death 28a. Date of Injury 28b. Time of	TIL 3D BOX 4D Notising Home	Describe how in	6 COther (Specifical Control of the Court of	Mospice
sior	ttanding I death. stor: After the funer	atio	2 Accident investigation	M 1 Yes 2 No			
Division of	s after d et Direct ed in by	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, si building, etc. (Specify)		ocation (Street City or Town, St	and Number or Rura ate)	nl Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	th occurred at the time, date and place, and divestigation, in my opinion, death occurred a	ue to the cause the time, date a	and place, and due to	lated. the cause(s)
	with To t	Σ	29b. Signature and title of certifier	29t. dicense number	29d. I	Date signed (Month,	Dey, Year)
			r surens. with	<b>レルトノイプ</b>	- 08	Nov.2	005
			30. Name and address of posson who completed cause of death (Item 23a) (Type Walter Recall Ing Medica 31. Date filed (Month, Day, Year) 32. Paristrar's Signature		sh D	12030	7
Sp.	Sta Registr	te ar	31. Date filed (Month, Day, Year) NOV. 1 6 2005	Speed of	10		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2005 November 1510 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1105 Ma timore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age 8. Date of Birth 80°s. 9. Birthplace (State or Foreign **Funeral** Hours June Day 2 Year 925 Months Days Maryland 215-76-077 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examinar must be putified at 10d. Inside City Limits MD Prince Georges Brandywine Director 1 XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9020 Dyson Rd. 20613 USA death Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. o filed within 72 hours after di Hygiene. other than "natural", or item 1 ∐Yes 2 MXNo If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Black 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Farming s f and 2 should be filed w f Health and Mental Hygier Item 27 is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Cornealus Savoy Bertha A. Dorsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Depertment of Health ar
Importent: If Item 27 is
any injury or other treu Julia E. Savoy/Sister 6713 Eilerson St., Clinton, MD 20735 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 11/21/05 Alexandria, VA 21. Signature of Ineral Service Licensee 22. Name and Address of Facility Adams Funeral Home, Aquasco, MD 20608 151 23a. Part1. Enter the disease, or complication, that shock, or heart failure. List only one cause on aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** evalo /Medical Due to **Examiner** dicepio Sequentially list conditions, if any, leading to immediate cause. Enter Underving Cause (Disease or injury that initiated events resulting in death) Last Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Box 68760 Physician/Medicai IF FEMALE. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 25. Was case gerred to medical examiner? 2 No Division of Vital Yes 2 **X** No 1 TYes or Attending Physician: Be ce of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Tyes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by efter 4 Homicide To the Hospitel within 24 hours e To the Funerel C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical pletely and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who comple of death (Item 23a) (Type, Print) S.S. DANG M.D. ST. HELENA BALTIMORE 101 31. Date filed (Month, Day, Year) State NOV 1 7 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** FANNY LEONARD SCHOR NOVEMBER 14, 2005 12:45 P.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Rockville Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea May 21, 1 Birthplace (State or Foreign Country) **Funeral** 1 M 2 T Director 578-46-9664 95 Yrs. 1910 Poland Poland Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at 1√Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? With 5 16016 Wallingford Road 20906 U. S. A. Items 23a Pages 1 and 2 should be filed within 72 hours after death Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Marned ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White þ Specify: 3 ☐ Widowed 4 X Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12 Years College (1-4or 5+) Merchant New Concession Stands 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be la marked o George Shuman Rachel (Unknown) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health a
Important: If Item 27 Is
any injury or other trau Michael Leonard - Son 16016 Wallingford Road, Silver Spring, Md 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/17/2005 | Olney, Maryland Judean Mem. Gardens 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License Edward Sagel Funeral Direction, Inc. Donald ( 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End Stage Bladder Cancer **Physician** Year /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical nding pus IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Feta! death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery atten for u 3 Ectopic pregnancy Month 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ Rectal Bleeding 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 1 Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 KOther (Specify) LIVING 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Diractor: After the completely tilled in by the tuneral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated the the 20 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061382 11-15-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14816 Physicians Lane, Suite 152, Rockville, Md 20850 Dr. Shana R. Mittal 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2005 Deve Registrar

			1 - For State Registrar	State of Maryla		artment of rtificate of			giene 0 0 5	39208
п	Physici	an	1. Decedent's Name (First, Middle, Las	*				2. Date of Dea Month		3. Time of Death
	/Medic Examir	al	Richard Orville S  4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	Novembe	r 17, 200 4c. County of E	
	Funeral		Northampton Manor 5. Social Security Number 6. Se		s. last birthday	Fred	erick	. 8 Date of Birth		derick
b	Director		217-12-1370	X M 2□F 81	Yrs.	Months Day		(Month, Day	1, 1924 M	Birthplace (State or Foreign Country) aryland
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or L	ocation				10d. Inside City Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene, itam 27 is marked other than "natural", or Items 23a or 28a-1 show other traumatic event, the Medical Eventiner must be notified at	tor	Maryland Frederi	ck Fr	ederic	k				1 ☐ Yes 2 ☑ No
	or 28	Oire	10e. Street and Number		CUCITO	10f. Zip Code			10g. Citizen of What	Country?
	ath w	rail	5917 Bryan Drive			21703			United	States
	ltems Der m	une	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		merican Indian, Vhite, etc.
21215-0036	urs aff al', or Exami	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☑ Yes 2 □ No 1 9 If Yes, Give Year or Dates: 1 0	142-	1 ☐ Yes 2 ☑ No	Specify:		Specify: W	hite
5-0	72 ho natur iical	eted	15. Decedent's Edu (Specify only highest grad	ucation	16a, Dece	dent's Usual Occi	upation	rking	16b. Kind of Busine	ess/Industry
121	12 should be filed within h and Mental Hygiene. 7 is markad other than " traumatic evant, the Med	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			e during most of wor ed)	King		
d 2	filed v Hygie other t		17. Father's Name (First, Middle, Last)		Mec	hanic	18 Mother's Nan	ne (First, Middle,	Automoti	ve
Maryland	ld be ental kad o	To Be	Orville Dewey Sti	telv				rene Fog	,	
ary	shou and M s mar umat	-	19a. Informant's Name/Relationship (T)		19b. Maili	ng Address (Stree			r, City or Town, Stat	e, Zip Code)
	and 2 ealth a n 27 l		Rick Stitely / So:		216	Albany A	venue W.,		ville, MD	
Baltimore,	Pages 1 nent of He int: If itan iry or oth		20a. Method of Disposition 1. □ Burial 2 □ Cremation 3 □ F	20b.	Place of Dispo cemetery, cre-	osition (Name of matory or other pl	ace) Nov	Date 19,	20c. Location - City	or Town, State
ţ	t. Pag tment tant:		`4 ☐ Donation 5 ☐ Other (Specify)	Res		Mem. Gar	dens 2		rederick,	Maryland
Bal	permit. Pages 1 and 2 s Department of Health ar Important: If itam 27 Is any injury or other trau once.		21. Signature of Fineral Service Livens	999	2. Name and Add esthaven 501 Cato	Funeral	Services	, Skkot C	ody P.A.	
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	/Medical Examiner		resulting in death)	Due to (or as a conse						years
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oʻ	ate be executed hysician and the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	quence of):					
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Ō	tal or rs afte ral Dir	OI	4 Tromicide	building, etc. (Speci	Ty)			City or Town	, State)	
	To the Hospital (within 24 hours at To tha Funaral Dicompletely filled i	edicai	29a. Certifier (Check only one)  Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifying Physical Certifier (Check only one)	sicien: To the best of my kniner: On the basis of examinating and manner stated.	owledge, death ation and/or inv	occurred at the trestigation, in my	ime, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
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			For State Registrar		State of	Maryla	and / Dep <i>Ce</i>	artmen rtificate				ental Hy	gien Reg. N	0005	39	209
de la			1. Decedent's Name (Firs	, Middle, Las	st)							2. Date of De	aath		3. Ti	me of Death
	Physici /Medio		Kathryn	France	s Smith							Month Nover		ay Year 17, 20	05 9	:10 a <sup>M</sup>
	Examir	ier	4a. Facility Name (If not in	stitution, giv	e street and num	iber)		4b. City,	Town, or L	ocation o	of Death			c. County of Dea	th	
		Ag	Frederic  5. Social Security Number				rs. last birthday	-	reder	ick If Under	24 Hrs			Frede		
	Funeral Director		172-26-2384		□ M 2 1 F	7. Age (#/ y	Yrs.	Months		Hours	Min.	3. Date of Bir (Month, Da	y, Year	9. Bir	thplace (Sountry)	tate or Foreign
3.2			Usual Residence of Dece	dent		, -					A	ugust	Ο,	1934 Pen	insy1	vania
	urylan show	_		County		10c.	City, Town or Le									ide City Limits
	8a-f	Director		rederi	.ck		New N	larket								Yes 2 No
	with th		10e. Street and Number 6118 Sam	uel Ro	ad			10f. Zip 217						itizen of What Co	ountry?	
	eath rs 23	era	11. Marital Status		12. Was Dece	dent Ever in	n II S   12			ania Ori	isio? (Cano	ify Yes or No		.S.A.	oogo lodi	
60	be filed within 72 hours after death with the Maryland hat hygiene.  ad other than "natural", or items 23a or 28a-f show event, the Modical Exacting must be redified at	Funeral	1 Never Married 2	Married	Armed For	ces? 2 ∰No		If Yes, spec	fy Cuban,	Mexican	, Puerto R	ican, etc.)	,	Black, Whit		arı,
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Baltimore, Maryland 21215-0036	should be nd Mental marked o	To Be	Edmund Cla	arke								nerine				
ary	A DE LE	þ	19a. Informant's Name/Re				19b. Maili	ng Address	(Street and	d Numbe				or Town, State,	Zip Code)	
Σ	and 2 salth a n 27 le		Gail Judd	- daug	hter		1726	Cast	le Ro	ck R	Road,	Frede	rick	, Maryl	and	21701
ore	ges 1 and 2 should to f Heatth and Men if Item 27 le marke or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crer		Removal from S		<ol> <li>Place of Disposers, createry, createry</li> </ol>	sition (Nam matory or ot	ie of her place)	1	Da			ocation - City or		
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Bal	permil. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra once.		21. Sign ture of Funerat S	ervide Licen	S00	011.	0 2	2. Name and	d Address	of Facilit	y Stau	iffer 1	Fune	ral Hom	е	
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	Physician /Medical		disease or condition resulting in death)		u		sequence of):	V CZZ							ZA	JOUTHS
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8760,	cate be executed physician and the burial-transit	E E	rosdang ar dodan, Last		Due to (c	r as a cons	sequence of):									
687	the death certificate be executed y the attending physician and Iched for use as the burial-transit	dical			d											
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	death d for	iciai	in the past 12 month. 1 Yes 2 No		1□Live bir 4□Pregna	nt at time o		Ectopic pre Other (spe						Month Month	Day	Year
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	9 P P P	þ	Part tt. Other significant of	onditions co	ontributing to dea	ath but not r	resulting in the u	nderlying ca	use given i	in Part I.		23e. Did to	obacco	use contribute to	the cause	e of death?
ord	w requir been si should	ted								-		101	/es 2	No 3□Pr	obably	4 Unknown
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ion	ath.	ation		Pending investigation	(Month	, Day Year)	) Injury	М	Work?	s 2 🗆 N				,		
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	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	CHOCK OTHY Z M	ertifying Phy edical Exam	sicien: To the biner: On the bas	est of my k	nowledge, death	occurred a	t the time,	date and	d place, and	d due to the	cause(s	) and manner as d place, and due	stated.	ISB(s)
	To the vithin 2 To the complet	Med	one) 29b. Signature and title of		and manne	er stated.			License no				11			
	8 4 & 4		Alm	1/80	mont	MI	ن		031		1			17/65		ar /
,	<u></u>		30. Name and address of	person who	ompleted cause	of death /III	tem 23a) (Tyne	Print)								
	IP		BRIAN M.	O'CON	32. Re	40 5	01 60,5	EVER	TH S	8/1	FA	EDEPL	de	MA	21	701
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	Registr	ar	17	OA T	ZUU5	Medical	w st	Spay	w							

			1 - For State Registrar	State of M	faryland / Dep Ce	artmer e <i>rtificat</i>			and Men		ene	5	392	10	
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	/Medic	al	V 4a. Facility Name (If not institution, give		AY SMITH	4h Cihi	Town or	Location o		vember	15, 2		1:00	A M	
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	Funeral Director		5. Social Security Number 6. Se 215–20–4024	7. A	ge (In yrs. last birthda) 78 Yrs.	/) If Under Months	n 1 Year Days	If Under 2 Hours	Min. Dec	Date of Birth Month, Day, C. 12,	l	9. Birth	nplace (State untry) Vland	or Foreign	
	pu >		Usual Residence of Decedent  10a. State 10b. County		10a City Tayya										
	shov	ō		1	10c. City, Town or	_ocation							10d. Inside C	ity Limits 2 ☐ No	
	28a-f	ect	Maryland Frederic	:K	Thurmont	10f. Zio	Code			10	g. Citizen of	What Car			
	3a or	0	1 West Moser Road	A-3			21788				U.S		у:		
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36	or Its	y Fu	1 Never Married 2 Married	1. La Yes 2 □	& IIWWII	1 ☐ Yes		Specify:	, ruento nicai	n, etc.)	Specif	ck, White			
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21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f show item "netural" or Items 1. and the recition at	Completed	(Specify only highest grad	e completed)	(Giv	e kind of wo DO NOT u	rk done di	uring most	of working	1	6b. Kind of B	usiness/ir	ndustry		
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<u>ة</u>	s 1 an f Heal item 2 other		20a. Method of Disposition	<del></del>	20b. Place of Disp	osition (Nar	ne of	1	Date	-	0c. Location -	- City or T	own, State		
altimore,	Page nent o int: If		1 Burial 2 ☐ Cremation 3 ☐ F  `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	R.R. Ch.	-		- 1	m. 11/	19/05	Rocky	Ride	e. Mai	rvlana	
Balti	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, If a Marital Ever It at Italian at once.		21. Signatur Fun-al Service, Lice	Xall	hat	22. Name an ROBERT	Address E.	of Facility	Y & SC	N, FUNI	ERAL HO	OMES.	P.A.	ryrand	
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	/Medical Examiner		resulting in death)	Due to (or as	s a consequence of):	عرب				-			year.		
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မင္ပင	e law n has be je 2 sh	Completed							2	24a. Was an autopsy	24b. \	Were auto	ppsy findings impletion of c	available	
		Con							1	perform	ed/2 (	death? 1 □ Yes			
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<u>o</u>	ath. r: Atte e fun	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year) Injury	М	Work? 1 □ Y	es 2□N							
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	itel o irs aft ral Di iled in	0													
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examination)	sician: To the best ner: On the basis of and manner st	of my knowledge, dea of examination and/or in ated.	th occurred a rvestigation,	at the time in my opii	, date and nion, death	place, and do n occurred at	ue to the cau the time, date	se(s) and ma a and place, a	nner as st and due to	tated. the cause(s	)	
	Yo the within To the compl	Me	29b. Signature and title of certifier			29c	License				I. Date signed		- ,		
)			Illan 7	Colires	MA DA	EI	37	19	7		11-1	7-	200	5	
1	14.0		30. Name and address of person who co	mpleted cause	death (Item 23a) (Type	Print)	7+1		بد ز		_				
	ρ.		Alan Kohre. 31. Date filed (Month, Day Year)	- MD		est	1-	Stre	7 cet F	redev	rick &	40	217	01	
	Sta Registr		NOV 1 8	2005 D	s Signature	does									

			1 - For State Registrar	State of Mary		partme e <i>rtifica</i>			nd Me	_	giene	5	39211
	Physici /Medic Examin	cal	1. Decedent's Name (First, Middle, La  4a Facility Name (If not institution, giv	M Sm	ITH X /AK	4b. City	, Town, or	Location of		2. Date of De. Month	Day Ac. County	/	3. Time of Death 1915 M
	Funeral Director	4	5. Social Security Number 6. S 219–18–7638 1  Usual Residence of Decedent	ex	yrs. last birthda Yrs.	y) If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da 2/22/1	h, Year) 925	Cou	place (State or Foreign ntry) yland
the Maryłan ו	r 28e-f ehow	Director	Maryland Wicomi  10e. Street and Number		c. City, Town or Salis	sbury	p Code				10g. Citizen of V		10d. Inside City Limits 1 Yes 2 □ No ntry?
hours after death with the Maryland	ral", or iteme 23a or 28e-f ehow Examirtet must be natilised at	by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	er Dr., Unit  12. Was Decedent Ever Amed Forces?  1					in? (Spec Puerto R	rfy Yes or No- ican, etc.)	USA  14. Rac Blac Specify	k, White,	can Indian, etc. hite
d within 72	piene. r than "natu the Medical	Completed	15. Decedent's Ec (Specify only highest graves of the secondary (0-12) 12	ucation de completed) College (1-4or 5+)	(Gi	cedent's Usi ve kind of w DO NOT	ork done d use retired	luring most )				d Pri	inting Co.
should be	h and Mental Hyg 7 is marked othe Iraumatic event,	To Be	17. Father's Name (First, Middle, Last) Martin Kleinsmit  19a. Informant's Name/Relationship (		19b. Ma	iling Addres	s (Street a	Clar	a Ma	rshall	Maiden Surnam	,	o Code)
es 1 en	of Healt if Item 2 ir other		S. Lee Smith/hus  20a. Method of Disposition  1 □ Burial 2 🖾 Cremation 3 □  4 □ Donation 5 □ Other (Specif	Removal from State	11 Ob. Place of Discemetery, constants	position (Na rematory or	ime of other place	9)	Da	te	209, Sal 20c. Location - Salisbu	City or To	
permit. Pages 1 e	Department Important: I any injury o		21. Signature of Funeral Service Licer	arney (	FSA	<sup>22</sup> Holla 501 S	nd Addres DWay Snow	Funera Hill I	al Ho Rd.,	ome Pro Salish	fession oury, MD	al A	ssociation
EX EX	ysician Medical Medical the prival-transit	lical Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	one cause on each line.	nsequence of):  /RNDUS  nsequence of):		,		2			5	Approximate Interval Between Onset and Death S-19 YIJAK
death certific	ned by the attending phydelached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death	□Ectopic p					23d. Dat Mor	e of delive	ery Day Year
law requires that the	been signed to should be deta	ρ	Part II. Other significant conditions c	ontributing to death but no	t resulting in the	underlying	cause give	n in Part I.		1 🗆 Y	es 217No	3 Prob	he cause of death?
The	ate has page 2	Be Completed	25. Was case referred to medical					26. Place (	of Death	24a. Was a autop perfor 1 Yes	med? d	Vere auto rior to coi leath?	psy findings available mpletion of cause of No
Phy	S 0	Certification: To E	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Yea	2 ☐ ER/Outpati 28b. Time Injury		28c. injury Work	r: 4 ☐ Nurs	sing Home	5 ☐ Resid			HOSPICE
ō:	n by		4 Homicide determined	28e. Place of Injury - building, etc. (S)	pecify)			a data and	28	City or Tow	n, State)		al Route Number,
To the Hos	within 24 hours a To the Funeral C completely filled i	Medical	(Check only one) 2 Madical Examone)  29b. Signature and title of certifier	illner: On the basis of exa and manner stated.	mination and/or	investigation 29	c. License	number	occurred	at the time, o	ate and place, a	(Month,	Day, Year)
10	Sta Registr		30. Name and address of person who all the state of the s	completed cause of death  26 266  32. Registrar's S		2000 u		CT	SA	+ Lisa	ary	us	1.21201

			1 - For State Registrer	State of Maryland /		artment <i>tificate</i>			and Me		ene	15	39212
	Physicia	an	1. Decedent's Name (First, Middle, Last) Ellen Bowling	Smith						2. Date of Death Month Novembe	Day	2005	3. Time of Death 12:09 A M
	/Medic Examin		4a. Facility Name (If not institution, give streets) 5909 Old Croom	eet and number)		4b. City, To		Location o		1101 (1115)	4c. Count	y of Death	
	Funeral Director		210-00-1000	7. Age (In yrs. last I	oirthday) Yrs.	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day, Mar 4,	1905	Сои	place (State or Foreign ntry) y land
	Marylend f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Ge	eorge's Up		cation Marlbo	ro						10d. Inside City Limits 1 ☐ Yes 2 🖫 No
	or 28a-	Director	10e. Street and Number			10f. Zip C				10	g. Citizen of		ntry?
	death w	Funeral	5909 Old Croom S	Was Decedent Ever in U.S.	13. V	Was Decede		20772 spanic Orig		cify Yes or No- lican, etc.)		USA	
2-0020	urs after o el', or Iter Everriner	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		f Yes, specify		Specify:	i, Puerto R	lican, etc.)	Speci	ack, White, ify: W	etc. hite
0-617	ges 1 and 2 should be filed within 72 hours after death with the Marylend it of Health and Mental Hygiene. If item 27 is marked other then "naturel" or Items 23a or 28a-f show if item 27 is marked other then "naturel" or Items 21ac in califical and or other treumetic event, the Madical Everth art mast be rediffical and	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)		(Give life. L	lent's Usual kind of work DO NOT use	done di retired)	uring most	t of workin	g 1	6b. Kind of E		
V	e filed within al Hygiene. I other then " vent, Inc Mo	a	17. Father's Name (First, Middle, Last)	4	SCII	ool Te			er's Name	(First, Middle, N			hools
	2 should be f and Mental h le marked of reumetic eve	To B	John		ling				ldre			alle	
Mar	nd 2 sh Ith and 27 le m r treum		19a. Informant's Name/Relationship (Type Ignatius Edelen (1			_				Route Number, Spur Ur			20.12
ore,	of Health of Health if item 27		20a. Method of Disposition 1  Burial 2 □ Cremation 3 □ Ren	20b. Place ceme	of Dispo	sition (Name	of er place	)	Nov.		Oc. Location		
Saltim	t. Pa rtmer rtent:		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Licensee	Resu		tion C		- 1	200	05 Funeral		ton,	
n	permi Depa Impo any ir		Gary J. Goff	7						and Blvo			MD 20736
			23a. Part. Enter the disease, or complica shock, or heart failure. List only one immediate Cause (Final	cause on each line.			•			9	st,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence		n	Fili	rill	ativ	2)			_
	Examiner	-	Sequentially list conditions, b	Due to (or as a consequence		r							3 mer
	outed d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence		ind	Real	2					3 .m2
8/60,	certificate be executed iding physician and ise as the burial-transit	al Exe	resulting in death) Last	Due to (or as a consequence	e of):							- 1	
20	tificate ng phys as the	fedical	d										
O. BOX	ath atter for u	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown		Ectopic preg Other (spec						ate of deliver	ery Day Year
rds, P.	es that gned b	d by P	Part II. Other significant conditions contri	buting to death but not resulting	g in the ur	nderlying cau	ıse give	n in Part I.		23e. Did tob	۷.		he cause of death?
Heco	stoien: The law requir certificate has been si irector, page 2 should I	omplete								24a. Was an autopsy perform	ed?	Were auto prior to co death? 1 \( \sum \text{Yes} \)	opsy findings available impletion of cause of
VItal	Physician: this certifica	BeC	25. Was case referred to medical examiner?	spital:			Otha			(Check only one	)		
10	Phy this ral d	n: To	27. Manner of Death	1 Inpatient 2 LERV	Outpatien  Time of Injury		c. Injury Work	at		e 5 Resider			(y)
DIVISION	or Attending Patter death. Director: After in by the funers	ertification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home,		M eet. factory.	1 🗆 Y	es 2□l	_			ber or Rura	al Route Number,
2	r e i	O	4   Hornicide	building, etc. (Specify)						City or Town,			
	To the Hospitel of within 24 hours at To the Funerel D completely filled i	edical		ian: To the best of my knowled r: On the basis of examination and manner stated.	and/or inv	estigation, ir	n my op	inion, deat					
	To the vithing to the the the the the the the the the the	Σ	29b. Signature and title of certifier	Attending Ph	M. U	29c. 1	License Di 4	number	3	29	d. Date signe	ed (Month,	Day, Year)
	25		30. Name and address of person who com David A. Boef	pleted cause of death (Item 23a chev, MD 19	1) (Type,	Print)  O Gra	110	rut	Fox	Lu. #	18,6	Bowie	5 20115 MU
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrats Signature									

		-	State of Maryland / Department of Health and Mental Hygiene  1 - For State State of Maryland / Department of Health and Mental Hygiene  1 - For State State of Maryland / Department of Health and Mental Hygiene  23a per Dr., 6850/12/05/05dhb  Reg. No.	5 39213
			Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Y	3. Time of Death
	Physicia /Medic		STANLEY A. SLONAKER 11 - 23 - 20	
I	Examin		4c. County of	Death
			ST CATHERINE'S NURSING CENTER	ERICK  Birthplace (State or Foreign
	Funeral		Months Days Hours Min. (Month, Day, Year)	Country)
	Director	}	Usuat Residence of Decedent	RRTANNA, PA.
	land ow		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Marylan f show lied at	ţ	MD FREDERICK THURMONT	1⊠Yes 2⊡No
	28a	rec	10e. Street and Number 10f. Zip Code 10g. Citizen of Wh.	at Country?
	3e of	Funeral Director	11 BROWN AVE. 21788 U.S.A.	
	death ms 2	Jer	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	American Indian, White, etc.
9	after or ite			WHITE
5-0036	72 hours after death with the Maryland natural', or items 23e or 28e-f show Iteal Exertine trust be notified at	d by	3 Widowed 4 Divorced Year or Dates: OIVEIVOWIV	
5-0	s filed within 72 hours. I Hygiene. other then "natural", rent, the Madical Ext	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working (Give kind of work done during most of working	ness/Industry
121	Althin ne.	шф	Elementary/Secondary (0-12) College (1-4or 5+)	TRUCTION
2	iled v Hygie ther t	ပိ	CARPENTER CONST 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
au	ontal l	Be C	TDA HENRY	
Maryland 2121	2 should be and Mental ia marked o	٦	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St	ate, Zip Code)
Z	Ith ar		RUTH A. SLONAKER/WIFE 11 BROWN AVE., THURMONT, MD. 21788	
ē,	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 ia marked other then "natural", or items 23e or 28e-f show other treumatic event, the Medical Examinational be notified at		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Ci	
9			1 Burial 2 Cremation 3 Kilemoval from State	Y SPRINGS, 17065
Baltimore,	2 2 E E		21. Signati e of Furgeral Service Licensee 7 7 1 22. Name and Address of Facility SKILES FUNERAL HI	
ä	Depa Impo any i		John M. Skiles 210 W. MAIN ST., EMMITSBURG, MD.	21727
	Ph sician /Medical Examiner		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	Approximate Interval Between Onset and Death
			Due to (or sa consquence of):	24 h
	<b>2</b>	iner	Sequentially list conditions, I asy, watering to intributation cause. Enter Underlying Cause (Disease or injury that initiated events  c	
	icate be executed physician and s the burial-transit	Examine	that initiated events resulting in death) Last  Due to (or as a consequence of):	Grup
60,	icate be execu physician and s the burial-tra	a E	Co. ed Had	
68760,	phys phys the	dicai	d. Secondary	1
	eath certific attending pl I for use as t	/Me	IF FEMALE: 23b. Was decadent pregnant 23c. If yes, outcome of pregnancy 23d. Date	of delivery
Вох	death certii e attending id for use a	Physician/M	23b. Was decedent pregnant   23d. Date   1   23d. Date   1   23d. Date   1   23d. Date   1   23d. Date   1   23d. Date   1   23d. Date   1   23d. Date	,
0		hys	9 Unknown 9 Unknown	
٦, ٦	requires that the de een signed by the a nould be detached f	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contrib	ute to the cause of death?
ğ	w require been sig should b	ed	atheroschiate Cardioloscula Nisland 1 Yes 2/100 3	☐ Probably 4 ☐Unknown
Records,	~ 9 70	Completed by	24a. Was an autopsy pri	ere autopsy findings available or to completion of cause of
H	The law ate has bage 2 t	EO	autopsy performed? de 1 ☐ Yes 2 🔯 No 1 🖂	ath?
of Vital	iicien: Th certificate rector, pag	Bec	25. Was case referred to medical 26. Place of Death (Check only one)	
<b>1</b>	Phyaicien: this certific ral director,	To	1 Yes 2 No. Hospital: 1 Inspecient 2 FP/Outpatient 3 DOA Other. 457 Nursing Home 5 Pacidence 6 Dother	(Specify)
D O	ding Pl			J
Division	Attending r death. sctor: After by the fune	Certification:	2 Accident investigation M 1 Yes 2 No	
Ž	or Att	Ħ	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number City or Town, State)	or Rural Route Number,
	ital c			
	To the Hospital or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier    Some control of the cause (s) and manner stated one)   29a. Certifier   Some coursed at the time, date and place, and due to the cause(s) and manner (Check only one)   Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)   And manner stated.	ner as stated. d due to the cause(s)
	the the	Med	one) and manner stated.  29b. Signature and title of certifier 29d. Date signed (	'Month Day Year)
	F % F 8		(1/1)	
7	i_		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	R 23, 2005
	Ø		ALAN CARROLL W. T. CAG.	
	Sta	te		
	Registr			

	Exa	amir
DIVISION OF VITAL RECORDS, P.O. BOX 68/60,	<ul> <li>Hospital or Attending Physicien: The law requires that the death certificate be executed to house after death</li> </ul>	za nous arrest death. e Fundata Director Afer this certificate has been signed by the attending physician and analytikad in by the fundatal director page 2 should be detached by use as the build-transit
DIVISION OF VITAL	Hospital or Attending Physicien:	Funeral Director: After this certification filled in by the funeral director of

			For State Registrar	State of M	aryland		rtment of tificate o				ene	)5	39214
	Physici	an	1. Decedent's Name (First, Middle, La: JEAN W. THURS							2. Date of Death Month November	Day	Year 2005	3. Time of Death 9:00 A M
	/Medic Examin		4a. Facility Name (If not institution, give				4b. City, Town	, or Location			20,	ty of Death	
			1040 S. Constitut				Pylesv					ford	
	Funeral Director			ex	e (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Day		Min.	8. Date of Birth (Month, Day, 1/4/1924	Year)		place (State or Foreign intry) Insylvania
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. fnside City Limits
	a-fsh	ctor	MD Harford		Pyles	sville	9						1 ☐ Yes 2 No
	h with the 23a or 28	al Director	10e. Street and Number 1040 S. Constitu	ition Road			10f. Zip Code 21	132		10	g. Citizen of U	What Cou	intry?
90	be filed within 72 hours after death with the Maryland Hygiene. All Hygiene. Ad other than "natural, or Items 23s or 28s-f show event, the Medical Examinar mast be indiffed at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 27 If Yes, Giver Year or Dates:	,		Vas Decedent of Yes, specify C			cify Yes or No- Rican, etc.)		ack, White,	ican fndian, , etc. nite
N-612	within 72 hou iene. then "natura ine Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)			16a. Decedent's Usual Occupation (Give kind of work done during most of working ifte. DO NOT use retired)  Homemaker					16b. Kind of Business/Industry  CWN Home		
Ě	o d fa	To Be Cor	12 17. Father's Name (First, Middle, Last) John Augustus Wol							(First, Middle, M		ıтө)	
-	d 2 shouth and N 7 is mail	Ĕ	19a. fnformant's Name/Relationship (				g Address (Stre			i Route Number, Exton		n, State, Zij 19341	
altimore,	permit. Pages 1 and 3 Department of Health Important: if Item 27 any injury or other tra		20a. Method of Disposition  1 ☐ Burial 2 🏋 Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		cen	netery, cren	sition (Name of natory or other p	place)	1/30/2		oc. Location		
0	permit. Departm Importa any inju		21. Sig re Funeral/Service License 22. Name and Address of Facility Harkins Funeral Home, Inc., 600 Main St., Delta, PA										
	hysician /Medical		21. P. 1. Ever the disection, or compock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a. Tho	ne. nevoh	10 B	r the mode of a	,		r respiratory arre	st.		Approximate Interval Between Onset and Death
ļ	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or influry	bDue to (or as									
,00,	cate be executed hysician and the burial-transit	Ical Examiner	that initiated events c.  The sulting in death) Last Due to (or as a consequence of):										
<u>.</u>	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal d	leath 3	Ectopic pregnal					ate of deliver	rery Day Year
cords, F.	law requires that the as been signed by th 2 should be detache	by	Part II. Other significent conditions of		out not result	ing in the ur	nderlying cause	given in Part I		23e. Did toba	1		the cause of death?
Ž	The lar ate has page 2	Completed	- a seconomis							perform	autopsy prior to completion of cause death?		empletion of cause of
VILA	ysiclen: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital:				Othor		(Check only one			
0 0	\$ SE D	tlon: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Inju	iry 2	R/Outpatien 28b. Time of Injury	28c. In	4 140	2	ne 5 A Resider 28d. Describe how			<i>(</i> y)
DIVISION	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Sertification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	9 28e. Place of In	ury - At hom c. (Specify)	ne, farm, stre	eet, factory, office	ce	28f. Location (Street and Number or City or Town, State)		ber or Rura	al Route Number,	
	n 24 hours n 24 hours he Funera	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysicien: To the best niner: On the basis o and manner st	f examination	ledge, death on and/or inv	occurred at the restigation, in m	time, date an y opinion, dea	nd place, a ith occurre	and due to the car ad at the time, da	use(s) and m te and place,	nanner as s , and due to	itated. o the cause(s)
	To the comp	Me	29b. Signature and title of certifier	1111			29c. Lice	ense number		29	d. Date signe	ed (Month,	Day, Year)
			- Del	//m	m	20-1-2	0	1797-	5		11/20	1/05	1
	15		30. Name and address of person who	0 0 44.00	peath (Item 2		print)	nd	140	Air, 1	un 2	1014	
	Sta Registr		31. Date filed (Month, Day, Year)	32. <b>P</b> (site	rar's Signatu			1	7 4	ager !			

ORIGINAL

			1- State of Maryland		artment of		Mentai H	ygiene	5 39215
	Physici	ian	1. Decedent's Name (First, Middle, Last) FRANCES THOMAS				2. Date of D Month Novem	Day	3. Time of Death 11:04 P <sub>M</sub>
	- /Medi Examir		4a. Facility Name (If not institution, give street and number)			n, or Location of De		4c. County	
	Funeral Director		370-20-0909	s <i>t birthday)</i> 2 Yrs.	If Under 1 Ye Months Da	ar If Under 24 H		irth	9. Birthplace (State or Foreign Country) Washington, DO
	Maryland B-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Montgomery	Town or Lo		r Spring			10d. Inside City Limits 1∭Yes 2 □ No
	3a or 28	i Dire	10e. Street and Number 12325 New Hampshire Avenue		10f. Zip Cod	20904		10g. Citizen of V	What Country?
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is merked other than "natural", or items 23a or 28a-f show or other treumatic avent, the Modical Examplar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Yes, specify C	of Hispanic Origin? Cuban, Mexican, Pu No Specify:	(Specify Yes or Nerto Rican, etc.)	lo- 14. Rac Blac	e - American Indian, ck, White, etc. c: Black
21215-0036	within 72 hou iene. Ithan "natura Ithe Woolcal E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	16a. Deced (Give life.		cupation ine during most of v tired)	vorking		f Employed
Maryland 2	should be filed and Mental Hygic marked other umatic avent, It	To Be Co	10 17. Father's Name (First, Middle, Last) Unknown			18. Mother's N	е На	e, Maiden Sumam	7e)
	1 and 2 sho Health and I Iem 27 is mu		19a. Informant's Name/Relationship (Type, Print)  Derrick F. Thomas (Son)			er Place		ber, City or Town, Spring, A	
3altimore,	Pa ant ary		1 M Burial 2 □ Cremation 3 □ Removal from State	netery, cren t Oli		place) letery 11,		Washir	City or Town, State
Balt	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service sicensee	4(	001 Beni	ning Road	, NE Wa	shington	
8760,	Physician / Medical Examiner students of the prize transit students of the prize transit of t	dicai Examiner	23a. Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions) of the conditions of the c	and only concepts:	ial axre	1 - 1/-	ease		Approximate Interval Between Onset and Death  Hows.  Years.
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Media	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1   Yes 2   XNo 9   Unknown   Unk	leath 3	Ectopic pregna			23d. Date Mor	e of delivery nth Day Year
ds, P.O.	uires that I signed by Id be deta	d by Ph	Part II. Other significant conditions contributing to death but not result	ing in the ur	nderlying cause	given in Part I.			nbute to the cause of death?  3 Probably 4 Unknown
Il Records,	iician: The law requir certificate has been s rector, page 2 should	Completed by						opsy p formed? d	Were autopsy findings available prior to completion of cause of leath?  Yes 2 No
of Vital	d is	To Be	25. Was case referred to medical examiner?  1  Yes 2 X No Hospital: 1 Inpatient 2 SE	R/Outpatien	it 3□ DOA	Other	eath (Check only Home 5 ☐ Res	one) idence 6 □Othe	er (Specify)
Division o	Jing After fune	Certification;	1  Accident	8b. Time of Injury		njury at Vork? □ Yes 2 □ No		how injury occurr	
Divi	fo the Hospitel or Attent within 24 hours after deatl fo the Funerel Director: completely filled in by the	Certifi	4 Homicide determined 288. Place of Injury - At hom building, etc. (Specify)				City or To	own, State)	er or Rural Route Number,
	To the Hospitel or A within 24 hours after To the Funerel Direct Completely filled in by	Medicai	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowl one and manner stated.	adge, death n and/or inv	vestigation, in m	y opinion, death oc	ce, and due to the curred at the time	, date and place, a	and due to the cause(s)
	Towns	2	29b. Signature and title of certifier  **RAMAN R- Cul;	*	D	19609		Novembe	er 16, 2005
2	(3)		30. Name and address of person who completed cause of death (Item 2)	3a) (Type,	Print) RA SUII	MAN. TEZOZ	R. TU GAITH	LI. M	1) R4 MU 20878
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 1 8 2005	La	18.0				

DENNIS	L.	TURNER	
05-07660			
RJ			F

			1 - For State Registrar	State of Ma		partment of F ertificate of			iene) ()	5 3	19216
9	Physici	20	1. Decedent's Name (First, Middle, Last)					Date of Deat     Month	Day	Year	3. Time of Death
	Physici /Medio		Dennis L. Turr					Novembe	r 12,	2005	2:34 p.M
	Examir	er	4a. Facility Name (If not institution, give s Doctors Community			4b. City, Town, or Lanhar	r Location of Death			ly of Death	orge's
		4	5. Social Security Number 6. Sex		(In yrs. last birthd		If Under 24 Hrs.	8. Date of Birth			
	Funeral Director			44 200 5	73 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Mar. 16	Year) . 1932		lace (State or Foreign try) ginia
			Usual Residence of Decedent					1141.10	11752		
	arylan show		MD Prince (		10c. City, Town o	t Height:	G			10	0d. Inside City Limits YEYes 2 □ No
	86-f	Director		leorges	DISCITO		<b>5</b>				
	with th	DIE	10e. Street and Number 1741 Addison Roa	∂ Co…⊥h		10f. Zip Code		11	Og. Citizen of	What Coun	itry?
	99th v	era		2. Was Decedent E	verintIS 1	20747 3. Was Decedent of H	ispanic Origin? (Spe	city Yes or No-	USA 14 Ba	ice - Americ	an Indian
215-0036	be filed within 72 hours after deeth with the Maryland tal Hyglene. d other then "netural", or Iteme 23a or 28e-f show event, the Medical Examiner must be mailled at	by Funeral	1 Never Married 2 Married 3 Widowed 4X Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	Specify:	Rican, etc.)	Bla	Black	etc.
9	72 ho	ted	15. Decedent's Educ	ation	16a. De	cedent's Usual Occup	ation	20	16b. Kind of E	3usiness/Inc	dustry
218	within 7 ene. then "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5-	-) lif	e. DO NOT use retired	1)				
21	filed with Hygiene. other ther	Con	6		Hea	vy Equipr					Lon
pu	be fill stal H od oth	Be	17. Father's Name (First, Middle, Last)  James E. Turner,	Can			18. Mother's Name				
3	should be filed nd Mental Hygi marked other umatic event,	2	19a. Informant's Name/Relationship (Typ		10h M	ailing Address (Street)	Ella Ma				Code
Maryland	d 2 sho th and th and 7 le m traum		Sheila Turner-Br						,		
	s 1 and 2 should if Health and Mer item 27 le marke other traumatic		20a. Method of Disposition	OWII, Daus	20b. Place of Di	sposition (Name of	and the last of th		20c. Location		
Baltimore,	Pages nent of 1 ant: If its ary or o		1 🔀 Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Pleasa Memori	nt varrey al Park	Nov	26.05	Annand	dale	Virgini
alti.	permit. Pages Department of Important: If i eny Injury or once.		21. Spature of Funeral Service License	9		22. Name and Addres	ss of FacilityGre	ene Fu	neral	Home	INC.
ä	70 E 9		helson The	ne		814 Frank	klin Str	eet-Ale	exand	ria,	VA 22314
1¢	*4		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused to cause on each line	the death. Do not	enter the mode of dyin	ig, such as cardiac o	r respiratory arre	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	EM ST		EMOL DIS	EDSE				Onset and Death
20.75	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):		<del></del>				
	LAMITHE		Sequentially list conditions, b.	D - 4- /							
	ed sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						
	cate be executed physicien and the burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):						
09/	sicier burit	alE									
68760,	ificate g phy as the	edical	0.								
Вох	death certifi e attending I od for use as	Physician/M	23b. was decedent pregnant	lc. If yes, outcome o		3 Ectopic pregnancy	,			ate of delive	ry
	0 0	sicia	in the past 12 months? 1 □ Yes 2 □ No	4 Pregnant at t		5 Other (specify)			M	lonth	Day Year
P.0	The law requires that the de ate hes been signed by the a bage 2 should be detached	Phys	9 Unknown								
Ś	res tha igned be de	þ	Part II. Other significant conditions con	inbuting to death bu	t not resulting in th	e underlying cause giv	en in Part I.		acco use con s 2 No		e cause of death?
oro	v requir been si should I	ted						1 10 16	5 2 110	3 L F100	abiy 4 Donknown
Record	The law cate hes b page 2 st	Completed						24a. Was an autops	24b.	Were autop	osy findings available appletion of cause of
al F	ician: Th certificate ector, pag							1 Yes 2	□No	1 Yes	2□ No
Vital		Be	25. Was case referred to medical examiner?	ospital:		tiont 30 DOA Oth	26. Place of Death				
of	Phys r this sral di	2:1	Yes 2 No ''' 27. Manger of Death	28a. Date of Injury	/ 28b. Tim	Hell DON	4   Nuising Hor	18d. Describe ho			")
on	Attending In death.	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) Inju		k? Yes 2 □No				
Division	of or Attendination of a structure of a structure of the structure of the function of the function of the structure of the st	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At home, farm,	street, factory, office	2	28f. Location (Str		ber or Rura	Route Number,
Ö	s afte	Cert	4 _ Hornicide	building, etc.	(Зр <del>в</del> спу)			City or Town	, 3(4(8)		
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 ☐ Certifying Phys (Check only one) 2 ★ Medical Examin	ician: To the best of er: On the basis of and manner stat	examination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, da	use(s) and m ite and place,	anner as sta , and due to	ated. the cause(s)
	To the within To the	Σ	29b. Signature and title of certifier	0 10		29c. Licens			d. Date signe		
ľ	0		Maryine 17	nelphell	LW	OCM	Æ	N	Iovembe	r 13,	2005
1	(5)		30. Name and address of person who cor		ath (Item 23a) (Ty	pe, Print) 111 P	enn Stree	t Balti	more,	Maryl	and 21201
			31, Date filed (Month, Day, Year)	10 Red L	r'e Signature						
	Sta Registi			Z. Hegistra	r's Signature						
DH	MH 17 Rev 1/2	_	NOV 2 1 2005	plane	No 140						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mar	ryland /	Depa <i>Cer</i>	artmen rtificat	t of H	ealth a	and M		Reg. No.	m	5 3	19217
П	Physici	an	1. Decedent's Name (First, Middle, Las Bertha C. Thou							ľ	2. Date of De Month OVEMD	ath Day	, 14. '	Year 2005	3. Time of Death 6:20AM
	/Medio		4a. Fecility Name (If not institution, give	-			4b. City,	Town, or	Location o				County		0.20A
	ZXXIIII		St. Mary's Hos	pital					ltowr					t Ma	ary's
	Funeral Director		5. Social Security Number 213-30-0423  Usual Residence of Decedent		(In yrs. last b	virthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da OCT • 7	, 193	3	9. Birthpl Count Mary	ace (State or Foreign rland
	Maryland a-f show ified at	ctor	10a. State 10b. County MD St. Mar		Char			all						10	0d. Inside City Limits 1 XYes 2 □ No
	th with the 23a or 28 ist be no	al Dire	10e. Street and Number PO BC RT 236 Thompson		Rd		10f. Zip	Code 2062	22			•	zen of W JSA	hat Coun	try?
980	ges 1 and 2 should be filed within 72 hours efter death with the Maryland to f Heelth and Mental Hygiene. If item 27 is merked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be maiffied at	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		- 1			spanic Ori n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-		c, White, e	an Indian, etc. ack
21215-0036	vithln 72 hone. han "natu e Medical	mpletec	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)			(Give life. L		erk done d se retired,	luring most )	of work	ing			siness/Ind	,
Maryland 2	2 should be filed withlr and Mental Hygiene. is marked other than aumatic event, the Mi	To Be Co	12 17. Father's Name (First, Middle, Last) Joseph B. Curt		1	rec	chni	Clar	18. Mothe		e (First, Middle, Brisc	Maiden			Government
	and 2 sho leelth and ! m 27 is me her traums	•	19a. Informant's Name/Relationship (Charles L. Tho		P	Э Во	ox 1	94 0		ott	e Hal	L, M	ID 2	0622	2
Baltimore,	permit. Pages 1 and Department of Heelth Important: If item 27 any injury or other tr once.		20a. Method of Disposition  1	1)	Quee	ery, cren	natory or o Î P∈	ace ace	1	11/	19/05	He	len,	City or Too	
Bal	permit Depar Impor any in		21. Signature of Sineral Service Licer	8)	111								asc	o, M	ID 20608
	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the one cause on each line a.  Due to (or as a	ac L	251	er the mod	AM /	g, such as	cardiac d	or respiratory a	rrest,		1	Approximate Interval Between Onset and Death
,0928	be executed siclen and burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a composition of the composition o	consequence	of):	<u> </u>	3040	3					N	NNUTES
687	ficate to physical first the total first the t	edical	•	d											
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physiclen and page 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	☐ Fetal deat		Ectopic pi Other (sp					2	23d. Date Mon	of deliver	ry D <b>ay</b> Year
rds, P.	quires that en signed b		Part II. Other significant conditions of	LUSIO D		in the ur	ndertying o	ause give	en in Part I.			obacco u /es 2[		bute to the	e cause of death?
Il Record		Completed by	ARPOMENAL	- ABSCE	55						24a. Was autop perte 1 1 es	rmed?	pi de	rior to com eath?	osy findings available apletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	100		(Check only o				
of	Phys this ral di	To :	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b.	utpatien Time of		28c. Injury	at		me 5 Resident				)
Division	il or Attending Fafter death. I Director: After d in by the funer	Certification:	1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		y - At home, i	Injury farm, str	M eet, factor		(? /es 2 □ I		28f. Location (S City or Tox			r or Rural	Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dit completely filled in	Medical C	29a. Certifier (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of e and manner state	xamination a	ge, death ind/or inv	occurred restigation	at the tim	e, date and pinion, deat	d place, th occurr	and due to the ed at the time,	cause(s) date and	and man place, a	ner as stand due to	ated. the cause(s)
)	To th Within To th comp	Me	29b. Signature and title of certifier	D				DOC		37			_		Day, Year) - 14, 2005
5	DB DL		30. Name and address of person who	completed cause of dea		) (Туре, <i>МС</i>	Print)	5	TNI	my	's /de	Spil	TAL		- 14, 2005
	Sta		31. Date filed (Month, Day, Year) 7	2005 32. Registrar	's Signature	4	dan.								

			For State Registrar	State of Ma	-	epartment of F Certificate of			iene ()	05	39218
			1. Decedent's Name (First, Middle	, Last)				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		Donald	Р		Tebo		Novembe	r 11,	2005	9:20 A <sup>M</sup>
	Examin		4a. Facility Name (If not institution				or Location of Death	1	4c. Coul	nty ol Death	
			Golden Years (		//			10 Day ( Dist		tgomer	У
h	Funeral		5. Social Security Number 030-30-1563	6. Sex 7. Age	e (In yrs. last birthd 65 Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day	, Year)		place (State or Foreign ntry)
	Director		Usual Residence of Decedent					January	1,194	0 Mas	sachusetts
	/lend		10a. State 10b. County		10c. City, Town o	r Location				1	0d. Inside City Limits
	Man	ţ	Maryland Montg	gomery	Potoma	с					1  Yes 2□No
	h the	Directo	10e. Street and Number	'		10f. Zip Code		l l	•	ol What Cour	*
	2 should be filed within 72 hours after death with the Maryland end Memberla Hygiene, end Memberla Hygiene, le marked other then "natural; or Items 23e or 28e-f show sumatic event, the Madical Examinar must be notified at	aiD	8209 Bucksı	oark Lane Wes	st		20854	Uı	nited	States	of America
	- dea	Funeral	11. Marital Status	12. Was Decedent 8 Apped Forces?	Ever in U.S.	<ol> <li>Was Decedent of H If Yes, specify Cub</li> </ol>	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- o Rican, etc.)		Race - Americ Black, White,	
36	or It	by Fu	1 Never Married 2 Marr	If Vac Give	10	1 ☐ Yes 2 No			Spe	cify: Wh	ite
Ö	ural'		3 Widowed 4 Divorced		960-1962	andanta Havel Conv	tion		10h Kind al	I Business/In	duate
ή	n 72 n nat	lete	(Specify only highes	t's Education st grade completed)	(6	ecedent's Usual Occup Give kind of work done fe. DO NOT use retire	during most of world)	king	160. Kind oi	Business/Inc	dustry
2	then then	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Grocer	<b>-</b> /		Re	tail	
Baltimore, Maryland 21215-0036	Hygie Other ent.		17. Father's Name (First, Middle,	Last)			18. Mother's Nam	ne (First, Middle,	Maiden Sum	ame)	
au	id be in wed o	To Be	Donald F. Tel	20			Rit	ta LaPie	rre		
JE Y	shound M	-	19a. Informant's Name/Relations		19b. N	failing Address (Street				vn, State, Zip	Code)
Š	nd 2 alth e 27 ie		Carolyn Tebo -	Wife	820	9 Buckspar	k Lane We	est, Poto	omac,	MD 208	354
ē,	E Her E		20a. Method of Disposition		20b. Place of D	isposition (Name of crematory or other pla	[			on - City or To	
Ë	Page In: I		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			Cemetery	11/14	4/05	01ne	y, Mar	yland
a	permit. Pages 1 and 2 should be Deperment of Health and Menta Important: If them 27 ie marked eny injury occupier treumatic evonce.		21. Sig rature of Funeral Saying	Licensee		Edward Ass	selfactione:	ral Direc	ction.	Inc.	
ñ	8 0 m 8			$\Rightarrow$		1091 Rock					1852
			23a. Part1. Erner the disease, or shock, or heart failure. List			enter the mode of dyi	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Colon (							Onset and Death
1	/Medical		resulting in death)	a	a consequence of)	:					
	Examiner		Sequentially list conditions	b							
-	D #	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		a consequence of)						
	and trans	Examiner	that initiated events resulting in death) Last	C. Due to for as	a consequence of).						
8760,	death certificate be executed e attending physician and ad for use as the burial-transit	E	,	Due 10 (07 as	a consequence or,						
87	physicate I	dicai		d							
×	ding	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				224	Date of delive	201
Вох	eath certific attending p	clan	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			Month	Day Year
P.0.	thet the de led by the a detached t	Physician/Me	1  Yes 2  No 9  Unknown	9□ Unknown							
	law requires thet the as been signed by th 2 should be detache		Part II. Other significant condition	ons contributing to death be	ut not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did to	bacco use co	ontribute to th	ne cause of death?
rds	n sign	d by			-11 . 12			1 🗆 Y	es 2.∏XNo	, 3 ☐ Prob	ably 4 Unknown
00	w requir s been s s should	Completed						24a. Was a		b. Were auto	psy findings available
Re	The lay ate has page 2	E						autops perfori	med?	death?	mpletion of cause of
ta	ilclan: Th certificate rector, pag	4	25. Was case referred to medica				26. Place of Dea	th Check only or			oup Home
>	Physician: rthis certifica ral director, p	To B	examiner? 1 ☐ Yes 2 🎇 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	atient 3 DOA	ner: 4 Nursing H	lome 5 Reside	ence 6 🔀	Dther (Specif	spice Gare
0	ding Ph After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pendir	28a. Date of Injur	ry 28b. Tim y Year) Inju	ne of 28c. Inju		28d. Describe h			
<u>ō</u>	Attending r deeth.	atle	2 Accident investi	gation			]Yes 2 ☐No				
Division of Vital Records,	or Attendater desti	Certification:	3 Suicide 6 Could 4 Homicide determ			, street, lactory, office		28f. Location (S City or Town	treet and Nu n, State)	mber or Rura	il Route Number,
	ospital or hours at hours at unerel D	ပိ	X								
	To the Hospital or Attending Physician: The I within 24 hours after deeth.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the best of Examiner: On the basis of and manner sta	examination and/o	leath occurred at the ti or investigation, in my	me, date and place opinion, death occu	red at the time, d	ause(s) and ate and plac	manner as si e, and due to	tated. the cause(s)
	To the vithin 2 To the comple	Med	29b. Signature and title of certifie	Α-	1180.	29c. Licen	se number	2	9d. Date sig	ned (Month,	Day, Year)
	F 3 F 8		, (	- Al	MIL	D356				er 11,	
	W		30. Name and address of person	who completed cause of d	eath (Item 23a) /Ti						
			Joseph Kaplan,			Philip Dr.	Olnev	MD 2083	2		
45.	Sta	ite	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	Louis 3	O THE Y				
	Regist	ar	NOV 1	7 2005	w B	The state of the s					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Month **Physician** PARGARE /Medical 4a Facility Nama (II not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner HEAR SCRED A
5. Social Sacurity Number RL RLAND RNY If Under 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 9. Birthplaca (Stata or Foraign 7. Aga (In yrs. lest birthday) 8. Data of Birth (Month, Day, 6. Sax **Funeral** Days 065-26-54 1□ M 25 F Director Usual Rasidance of Dacedent Pages 1 and 2 should be filed within 72 hours after death with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits or items 23a or 28a-f show Department of Health and Mental Hygiena. Important: If Nem 27 is marked other than "naturel", or frems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 Yas 2 No Be Completed by Funeral Director NERAL 10g. Citizan of What Country? 10f. Zip Coda 10e. Street and Number 750 26 F5 12. Was Decedant Evar in U,S. Armad Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Race - Amarican Indian, Black, Whita, etc. 14. Ráce -11. Marital Status 1 Yas 2 No If Yas, Give Yaar or Datas: 1 Navar Marriad 2 Married Specify: BLAC Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 4 Divorced 3 Widowed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grade complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) OME MAKER 18. Mothar's Nama (First, Middla, Maidan Sumama, 17. Fathar's Nama (First, Middla, Last) DAVIS 19b. Mailing Addrass (Straet and Number or Rural Routa Numbar, City or Town, State, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) NADINE TRONPSON-Smith 10475 20b. Place of Disposition (Nema of cematery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata
4 ☐ Donation 5 ☐ Othar (Specify) EMETERY 21. Signatura of Funaral Sarvice Licensaa m 23a. Part1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arreshock, or heart failure. List only one cause on each line. Approximata Interval Batween Onsat and Death **Physician** Immediata Cause (Final disaasa or condition rasulting in death) /Medical a ENDSTAGE COLOWARY YEXBS Examiner Dua to (or as a consaquanca of) Be Completed by Physician/Medical Examiner the Hospital or Attending Physician: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the causa of death? 3 □ Probably 4 Unknown 1 Yes 2 No 6BSTRUCTIVE PULLDONARY DISEAST 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? SEVERE CONSESTIVE HEART EVILYME 2 No 1 ☐ Yes 2 ☐ No within 24 hours after deeth. To the Funeral Director: After this certificata t complataly filled in by the funeral director, pag 1 🗆 Yes 25. Was case refarred to medical axaminer? 26. Plece of Death (Check only ona) Hospital: 1 Inpatiant Other: 4 Nursing Homa 5 Rasidance 1 Yas 2 No edical Certification: To 2 ER/Outpatient 3□ DOA 6 ☐Othar (Specify) 28a. Data of Injury (Month, Day Year) 28c. injury at Work? 27. Menger of Deeth 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 2 Accidant 5 Panding 1 Yas 2 🗆 No invastigation 6 Could not be determined 3 ☐ Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Numbar or Rural Route Number, City or Town, Steta) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, dete and placa, end due to tha cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner steted. 29a. Cartifiar (Check only one) 29c. Licensa number 29d. Data signad (Month, Day, Year) 29b. Signatura and title of certifie 30. Nama and address of person who completed ceuse of daath (Itam 23a) (Type, Print) JESUS 34 FROST BURG, MD 31. Date filad (Month, Day, Yaar) 32. Registrar's Signatura State DEC 0 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Amend ITEM #10f&19b PER FH **C8**50010424221/**D5**217H Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year November 28, 2005 4:30 Birch /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 236 E. Irvin Ave. Washington Hagerstown If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye Jan. 16, 9. Birthplace (State or Foreign **Funeral** Year 1931 Maryland 1 ☐ M 2 🗓 F 74 Jan. 218-28-4972 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ehow r than "natural", or iteme 23a or 28e-f ehov the Modical Examiner must be notified at 1 X Yes 2 □ No Funeral Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 236 E. Irvin Ave. 21742 U.S.A. filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. Teacher Child Care . Pages 1 and 2 should be filed w tment of Health and Mental Hygie tent: If Item 27 ie marked other ti iury or other traumatic event, IL. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank F. Birch Asulia Huntsman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack L. Willock/Husband 236 E.Irvin Ave., Hagerstown, MD 21740 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or Smithsburg Crematory 11/29/2005 | Smithsburg MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel S. Men 21742 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Lung Cancer 5 Mouths /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, fary leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner rsicien and e burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medicai phys the L as nse. IF FEMALE: . If yes, outcome of pregnancy 1□Live birth 2□Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? res 2 No page 1 Yes 25. Was case referred to medical 26. Place of Death Check only one examiner? Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To his 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation after death Director: the 6 Could not be determined 28l. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours at To the Funerel D completely filled it Dertifying Physician: To the best of my kindwidge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 202 Certifier Medicai (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D28365 11-24-05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street- Hogeston 368 MANZAR 31. Date filed (Month, Day, Year) 32. Rg State 2005 Registrar

For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 23b 25 per me 879 5-6-08 yt
State of Maryland Department of Health and Mental Hygiene
Amend Item 23a per me, g8/9 05/13/08dhb

Reg. No.

39222

5 ×	Physician
1	/Medical
	Examiner
	Funeral
200	Director

permit.
Departr
Imports
any in Physician /Medical Examiner The law requires that the death certificate be executed physician ar s the burial-to as the attending p cate has been signed by the page 2 should be detached After this certificate Funeral Director: in by within 24 To the

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 23, 2005 3:30 PM M Workman Robert Shane 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Mt. Airy Frederick Kline Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 23, 1959 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**∑**M 2□ F 212-78-2976 Pennsylvania 46 Yrs Usual Residence of Decedent iiit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland criment of Health and Mental Hygiene. crtant: if item 27 is marked other than "naturel; or iteme 23s or 28s-f show injury or other traumatic event, the Medical Examination man. 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 □ No Frederick Frederick Maryland Directo 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 21702 U.S.A. 1100 Wilson Place Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1X Never Married 2 Married 1 Tes XX No Specify: White Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Never Worked None 0 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle, Last) Be Mildred Dillow Jerry Lee Workman ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1403 Valley Lane, Woodbine, Maryland 21797 Connie Trent, sister 20a. Method of Disposition
1 ☐ Burial 24 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Smithsburg Crematory Nov. 26, 2005 Smithsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Keeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21. Signalore of Funeral Service Liber see M00255 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PrevMonia Aspiration Due to (or as a consequence of): Seizure Disorder of Unknown Etiology CERTIFICATION APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 2 No 1 TYes 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Hospital: 1 🗀 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA HOSPICE 27. Manny of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Injury 1 TYes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 — ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DOULIUTI eat (fem 23a) (Type, Print) are ASSO UNO SUIQIE

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. U 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 15 2005 NOVEMBER **Physician** 3:25 P WILLIAMS JAMES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 (Month, Day, Year) JANUARY 27 1938 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1₩ 2□ F Days Hours VIRGINIA 66 Director 230-52-0381 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a State 10h County traumatic event, the Medical Examiner must be notified at WASHINGTON, DC 1ÆYes 2□No Director DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 20011 5326 ROCK CREEK CHURCH ROAD N.E. U.S.A. Items 23a Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Itam 27 Is marked other then "natural", or Items 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PRIVATE CARPENTER 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ETHEL FERGUSON JOHN SIDNEY WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13822 LORD FAIRFAX PL. UPPER MARLBORO, MARYLAND 20772 ELNORA UZ ZELLE/SISTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Emporia, Virginia 11/21/05 ANTIOCH Cemetery ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licenses 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, shock, or heart failure. List Approximate Interval Between Onset and Death r complications that caused the death. I only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final acut **Physician** disease of condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transi that initiated events the attending physician and resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown n signed by tl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To Manner of Death 28d. Describe how injury occurred 28b. Time of After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a To tha Funeral I 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number **D46998** 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 16, 2005 3415 HAMWHM ST Hyaffsulle, MD20782 31. Date filed (Month, Day, Year) State Registrar NOV 1 8 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 11/14/2005 3:10 Violet Day Weisner /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gambrills Anne Arundel Kris Leigh Assisted Living If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02/27/1916 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🛣 F Pennsylvania 89 Director 187-10-8447 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelth and Mental Hygiene. important: if item 27 is marked other then "naturel", or iteme 23a or 28e-f ehow any injury or other freumatic event, the Medical Examinat must be routified at once. 10a. State 10b. County 1 ☐ Yes 2X No Funeral Director Anne Arundel Pasadena Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21122 1311 Water Oak Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2\tilde{\tilde{X}} No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Be Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Edna Aldinger Harry C. Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1311 Water Oak Drive Pasadena, MD 21122 David Weisner/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evangelical Cemetery 11/17/2005 Potosi, PA

22. Name and Address of Facility Robert E. Evans Funeral Home 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Coronary /Medical Due to (or as a consequence of) Examiner mentia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner or Attending Physicien: The law requires that the death certificate be executed ettending physiclen end for use as the burial-translt cubitus that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No s efter death. investigation 2 Accident 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0053556 November 15, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Crofton, MO 21114 1684 Villag Green 32. Restrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Nov 25 2005 Raymond Dale Woods /Medical 4a. Facility Name (If not institution, give street and number)
1507 Ave D 4b. City, Town, or Location of Death St. Leonard 4c. County of Death Examiner Calvert 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5 Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1₽M 2□F Months Days Hours 64 372-42-7094 Yrs. Director May 13, 1941 Ohio Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10a, State 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Calvert St. Leonard 1 Yes 2 No Director 10f. Zip Code 20685 10g. Citizen of What Country?
United States 10e. Street and Number ò 1507 Ave. D permit. Pages 1 and 2 should be filed within 72 hours after death 1 Depertment of Health and Mental Hygiene Important: if Item 27 is marked other than "natural", or items 23a any jujury or other traumatic event, the Madical Examiner muser 2008. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specifywhite þ 72 - 843 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ordinance mechanic US Navy 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Willard Woods Hazel Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1507 Ave. D. St. Leonard MD 20685 Darlene V. Woods - wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place)
Nov 26 2005
Metropolitan Funeral Service Alexandria Virginia 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Proces Colored a consequence of): disease or condition resulting in death) Sauamous NUCOSIVE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) ng physician and as the burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No nis certificate h I director, page 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 / Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DO062288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MIKHIL UPPALJOO Hospital 24 Prince hederick mo 31. Date filed (Month, Day, Year) 32. Registras Signature State NOV 2 8 2005 Registrar

			1 - State of Maryland /		artment of H			ene	5 3	9226
	Physici		1. Decedent's Name (First, Middle, Last)  Marvin Clay Wood			<del>-</del> .	2. Date of Death Month Novembe	1	1005	3. Time of Death 9:26 a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  Laurel Regional Hospital		4b. City, Town, or Laure	Location of Death		4c. County of	of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 212–20–1616 2 M 2 F 81	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCt. 22	, 1924	9. Birthpla Country Mary	ce (State or Foreign y) and
	he Maryland 8a-f show offlied at	ector		own or Lo						d. Inside City Limits 1 X Yes 2 □ No
	h with th	al Dir	200 Ft. Meade Road, Apt. #8		10f. Zip Code 20707	•	10	g. Citizen of W	hat Countr	y?
036	permit. Pages 1 and 2 should be liled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event. I'm Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates: 1942-4		Was Decedent of Hi f Yes, specify Cuba □ Yes 2 X No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black	- Americar k, White, et Whit	c.
Maryland 21215-0036	within 72 ho ene. then "naturi he Medical I	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	tent's Usual Occupa kind of work done o DO NOT use retired Manager	luring most of work	ring	6b. Kind of Bus		,
nd 2	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)		manager		e (First, Middle, M	aiden Sumame		.1011
aryla	should nd Men marka umatic	٦	Walter H. Wood  19a. Informant's Name/Relationship (Type, Print)	9b. Mailir	g Address (Street a	Hester	Ander		State, Zip C	code)
e, K	l and 2 Health a Im 27 is		Cynthia S. Vince, daughter	3630	Redhaven	Lane, H	untingto	wn, MD	2063	9
Baltimore,	Pages 1		Ceme Ceme	etery, cren	sition (Name of natory or other place oln Cemete	e) l		oc. Location - ( Brentwoo		
Balti	permit. Departm imports any inju		21. Sign we of Funeral Service License Leebaut	R	Name and Address	eral Hom		_	, MD	20736
000	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. It shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Cerebral information as a cerebral cause or condition as a cerebral cause (Final disease or condition cause).	arct		g, such as cardiac	or respiratory arre	st,	li C	Approximate interval Between Diset and Death NUTES
þ	Examiner		Due to (or as a consequence atrial fibri		on					
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that initiated events	ce of):						
8760,	icate be executed physicien and the burial-transit	dical Exa	resulting in death) Last  C. Due to (or as a consequence of the conseq	ce of):						
.O. Box 68	death certiff e attending ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 9 ☐ Unknown	ath 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th D	ay Year
S,	sign sign	by	Part II. Other significant conditions contributing to death but not resultin	g in the ur	nderlying cause give	on in Part I.		_		cause of death?
Vital Record	The law ate has b page 2 s	Completed					24a. Was an autopsy perform 1 Yes 2	ed? de	ior to comp eath?	y findings available bletion of cause of No
f Vita	Physician: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes  No  Hospital: 1 ☐ Inpatient 2 Hespital: 1 ☐ Inpatient 2 ☐ Inpat	/Outpatien	t 3□ DOA Othe	AC.	h (Check only one ome 5 - Resider		r (Specify)	
ion of	i or Attending Ph after death. Diractor: After th in by the funeral		27. Manner of Death  1X Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 281	b. Time of Injury	28c. Injury Work	at	28d. Describe hov			
Division	al or Atte s after des il Diracto ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	eet and Number State)	r or Rural F	Route Number,
	To the Hospital or At within 24 hours after of To tha Funeral Diract completely filled in by	edical (	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowled conditions on the basis of examination and manner stated.	dge, death and/or inv	occurred at the tim restigation, in my of	e, date and place, pinion, death occur	and due to the car red at the time, da	use(s) and man te and place, ar	ner as state nd due to th	ed. ne cause(s)
)	To th within To th comp	Me	29b. Signature and title of certifier	un	29c. License	3916		d. Date signed		
1	141		30. Name and address of person who completed cause of death (Item 23 William A. Warren, M.D. 321 Pr		Print) George S	t Taun	a] MD 20	1707		
Ĭ	Sta		31. Date filed (Month, Day, Year)  NOV 1 5 2005			Jey Laul				
	Registi	ar	MAA T 2 TAND VORTORS	10.	Marie					

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician NOV. MARY WEBER 2005 9:40 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ATLANTIC GENERAL HOSPITAL BERLIN WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🕅 F Yrs. Director 214-14-8290 OCT. 28, 1921 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show 1 XYes 2 No SUSSEX DELAWARE SELBYVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 47 EAST MILL POND DRIVE 19975 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ WHITE 3 X Widowed 4 ☐ Divorced "naturei", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 **BEAUTICIAN** HAIR CUTTING 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lipiry or other traumatic event ODEs. 18. Mother's Name (First, Middle, Maiden Surname) JOSEPH DOMINO CONCETTA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JO ANN MILLER/DAUGHTER 47 EAST MILL POND DRIVE, SELBYVILLE, DE. 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) CREMATORY OF DELMARVA 11/14/05 DELMAR, DELAWARE 21. Signature | Fyneral Service Lious 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part I. Enter the disease, or complications that crused the shock, or heart failure. List only one cause on ach line. death. Do not enter the mode of oying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumm Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 0 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No mmz 1 Yes 2/No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No I Director: / ₽ ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ ff Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. Medicai 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) Kohn MD 7733 Healthorin Berlin KO. 21 31. Date filed (Month, Day, Year) State NOV 1 6 2005 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend Item #5 State of Maryland / Department of Health and Mental Hygiene WCHD/SH 11/29/05 per FH Certificate of Death Reg. No. UU5 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dey **Physician** Marion Grace Wennerberg November 20 2005 8:45 AM /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Williamsport Williamsport Nursing Home Washington County 5. Social Security Number 505-34-2341 504-34-2341 If Under 1 Year 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. Director 83 8 Canada Usuel Residence of Decedent death with the Maryland 10a Stete 10b. County 10c. City, Town or Location **ehow** 10d. Inside City Limits r than "naturel", or items 23a or 28e-f eho The Medical Examiner must be notified at 1 ☐ Yes X☐ No Director Maryland Washington Hagerstown 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10213 Bear Creek Drive U.S.A.

14. Race - American Indian,
Black, White, etc. 21740 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 end 2 should be filed within 72 hours efter. Department of Health end Mentel Hygiene. Important: If Item 27 ia marked other than "natural", or ite any Injury or other traumatic event, the Medical Examina 1 ☐ Yes 2 X No 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: White چ و 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Personal Residence 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Albert Nash Ruth Elenora Jennings Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arvid L. Wennerberg (husband) 10213 Bear Creek Drive Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Memorial Gard | 11-23-05 Marriotsville Marylan 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown Maryland 21742 uncho, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cades on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Aspiration Pneumous week Examiner Completed by Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 1 ☐ Yee 2 No 3 Probably 4 ☐ Unknown ours efter deeth. erel Director: After this certificete hes been sir filled in by the funeral director, page 2 should i Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e

To the Funeral C

completely filled 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 22, 2005 Howe. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOWE 17 H-6 ARTIZAN ST. N. WILLIAMSPORT. 31. Date filed (Month, Day, Year) 32. Registrer's Signature

State

Registrar

NOV 2 3 2005

			For State Registrar	State of Maryland		artment of H		_	giene	5 39229
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last     Second	WINDER	7	4b. City, Town, or	Location of De	2. Date of De Month	ath Ac. County	Year 3. Time of Death 3005 5:30 P M of Death
200	Funeral Director		219-34-3582	CE   J   x   7. Age (In yrs. In   M XX   100	AKE ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	8. Date of Bir (Month, Da Sept. 1	(M) th Year) 2, 1905	9. Birthplace (State or Foreign Country) Maryland
	e Maryland	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Wicomico		Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Ptygene. Important: If Item 27 ie marked other then "natural, or items 23e or 28e-f ehow important: If Item 27 ie marked other then "natural, or items 23e or 28e-f ehow stripluty or other traumatic event, it a Madical Example must be notified at ance.	Funeral Director	10e. Street and Number  5822 Nebo Road  11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U.S Armed Forces? 1 UYes 2 M No				(Specify Yes or No erto Rican, etc.)	Bla	ce - American Indian, ck, White, etc.
21215-0036	within 72 hours ane. then "natural",	Completed by	3 ⊠ Widowed 4 □ Divorced  15. Decedent's Edition (Specify only highest grade)  Elementary/Secondary (0-12)  11th		16a. Dece (Give life.	1 Yes 2 No  dent's Usual Occup kind of work done of DO NOT use retired		working		usiness/Industry
Maryland 2	should be filed and Mental Hygid marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, Last) William	Wailes	labo		Mildred		Α.	<sub>пе)</sub> Hawkins
	Pages 1 and 2 shonent of Health and int: If Item 27 le miry or other traum		19a. Informant's Name/Relationship (T)  Catherine W. Parson  20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ F	s/daughter	1305 ace of Dispo	West Road sition (Name of matory or other place	d - Sa	lishury, M	aryland	
Baltimore,	permit. Page Department of Important: If eny injury or once.		4 Donation 5 Other (Specify) 21 Sign ture of Funeral Service Licens	Gre Jolley	2:	2. Name and Address  JOLLEY M	EMORIA	213 Jerse AL CHAPE	y Road L	y, Maryland - Salisbury, MD 21801
F-3	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ications that caused the death ne cause on each line.  A HZ her  Due to (or as a consequence)	mer	ter the mode of dyin	g, such as card		rrest,	Approximate Interval Between Onset and Death
8760,	examiner the british the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence.	,					
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ords, P	w requires that been signed b should be deta		Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	inderlying cause give	en in Part I.	23e. Did t	~	tribute to the cause of death?
Vital Records,		Be Completed	25. Was case referred to medical				26. Place of I	24a. Was autor perfo	osy No No	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Division of V	Attending Physician: If death. Sector: After this certificity the funeral director.	은	27. Manner of Death 12. Natural 5 Pending 2 Accident investigation	-lospital: 15 Inpatient 2 1 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injun Wor	4 1 14013111	g Home 5 Resultable Re	dence 6 □Oth	
DİVİ	i di di	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify sician: To the best of my known	vledge deat	h occurred at the tin	ne date and ol	City or Tol	wn, State)	ber or Rural Route Number,
•	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Examination Medical Exam	iner: On the basis of examinat and manner stated.	ion and/or in	29c. Licens	pinion, death o	ccurred at the time,	date and place,	and due to the cause(s)
	10d		30. Name and address of person who c	IMM Coxagle	1 Has	Print)  Pil P	O BOX	1733 &	alish,	11-05 mo 21802
長の後	Sta Registi		31. Date filed (Month, Day Year) 1 6 2	32. Refistrar's Signat		parte		and the second s	0,	

			1 - For State Registrar	Amend It	State of Mer.	Maryland verb.	d / Depa , <b>G85</b> 0	artment of F 12/05/05 willcate of	lealth <b>Shi</b> h	and M	fental Hy	gien Reg. N	2005	5	3923	0
	Physici /Medi			ne (First, Middle, Las C. Weis							2. Date of De Month NOV.	21 <sup>D</sup>	ay 200 <sup>Y</sup>	ar O	3. Time of Dea	
	Examir		4a. Facility Name	(If not institution, give	street and number	r)		4b. City, Town, or	r Location	of Death		-	c. County of [			
				Bishop				Cumberl					Alle	an	V	
	Funeral Director		5. Social Security 214-01-	-0109 1	9X 7. A □M 2√2 F	Age (In yrs. Ia	ast birthday) Yrs.	Months Days	If Under Hours		8. Date of Bi (Month, D NOV . 2	rth 26 <b>γ</b>	9.	Birthol	ace (State or For ry) ryland	reign
	and		Usual Residence of 10a. State	of Decedent 10b. County		10c. City	Town or Lo	cation						10	ld. Inside City Li	mite
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	th the or 28e	lrec	10e. Street and No					10f. Zip Code				10g. C	itizen of Wha	t Count	ry?	
	ath will	rai D	1050 E	Bishop W	alsh Roa	ad		215	02			τ	JSA			
980	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "neturel", or liems 23s or 28e-f show od other than "neturel", or liems 23s or 28e-f show event, the Medical Exercitres must be notified as	by Funeral Director	21	ried 2□ Married 4□Divorced	12. Was Deceden Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	s? ]No		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2☐ No	ispanic Or an, Mexica Specify:	igin? (Spen, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - A Black, V Specify:	Vhite, e		
2-0	72 hor	ted	(Soo	15. Decedent's Ec	lucation		16a. Dece	dent's Usual Occup	ation			16b.	Kind of Busin			
21215-0036	e filed within all Hygiene. I other than "r	Completed	Elementary/Sec 12		College (1-4or	r 5+)	life.	kind of work done of DO NOT use retired Dervisor	1)	it of work	ing	16				
	filed I Hygi other	Be Co		(First, Middle, Last)			Dur	CI VISUI		ər's Name	(First, Middle		nufac n Sumame)	ctu:	rina	
ylar	should be nd Mental marked o	To B	Conrad	Weisenb	orn				Chr	ist	ina Kn	ier	iem			
, Maryland	de E		19a. Informant's N Carl F	lame/Relationship (7 Pressman		ephew	19b. Mailir 81	ng Address <i>(Street a</i> LaVale	and Number Cour	er or Rura	A Route Numb	er, City	or Town, Sta	tө, Zip (		
Jore	ages 1 g nt of He : If item			Cremation 3		_ cei	metery, crer	sition (Name of natory or other place			Date		ocation - City			
Baltimore,	permit. Pages 1 and 2 Department of Heelith a Important: If item 27 is any injury or other tra once.			5 ☐ Other (Specify uneral Service Licen		Rest		n Mem G								
	Pern Dep Imp			ouxas I	State	N		1302 Na	tion	al E	Iwv.,	Lav			21502	
			shock, or nea	the disease, or compart failure. List only	one cause on each	line.						rrest,	·		Approximate Interval Between Onse <b>t</b> and Death	
	Physician /Medical		fmmediate Cause disease or conditi- resulting in death)	on				lar ac	cio	len	1			7	days	
	Examiner				. Due to (or a	s a conseque	ence or):								1	
		iner	Sequentially list of any, leading to it cause. Enter Und Cause (Disease of that initiated event	onditions, mmediate erlying	Due to (or a	s a conseque	ence of):							1		
_	and I-trans	Examiner	that initiated event resulting in death)	r injury is Last	c. Due to (or a	s a conseque	ance of):									
68760,	ifficate be executed g physicien and as the burial-transit	edicai E		l	d	3 4 00/130446	5/100 Or).							l		
	artifica ing ph a as th		IF FEMALE:													
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/M	23b. Was deceder in the past 12 1 Yes 2 9 Unknown	2 months? □ No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 ☐ Fetal c	death 3	Ectopic pregnancy Other (specify)					23d. Date of Month		/ ∂ay Y <i>e</i> ar	
	res that signed b	by	Part II. Other signi	ificant conditions co	ontributing to death	but not result	ting in the ur	nderlying cause give	en in Part I.						cause of death?	
öro	w require been sign should to	eted									10	Yes 2	□No 3□	Proba	oly 4 Unkno	IWI
Vital Records,		Completed									24a. Was autop perfo		prior death	to com	sy findings available to the control of cause   No	of of
Vita	Physician: this certific ral director,	Be	25. Was case refe examiner?	Ē	Hospital:			25 pos Cthe			(Check only o					
of	0 - 0	- To	1 Yes 2 27. Manner of Dea		28a. Date of Inj	iury 2	R/Outpatien 28b. Time of	1 3 □ DOA 28c. Injury	4 LI NU		ne 😥 esi 18d. Describe l		6 □Other (S	pecify)		
ion	Attending Ph ar death. rector: After th by the funeral	atio	1 Natural 2 ☐ Accident	5 ☐ Pending investigation	(Month, D	ay Year)	Infury	Work	? ⁄es 2 □ !				., 00001100			
Division of	al or Atte	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place of Ir	njury - At hometc. (Specify)	e, farm, stre	eet, factory, office		2	28f. Location (S City or Tox	Street a vn, Stati	nd Number or e)	Rural	Route Number,	
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer.	Medical C	29a. Certifier (Check only one)	1 Certifying Phy 2 Medical Exam	sician: To the besi	or examinatio	ledge, death on and/or inv	occurred at the timestigation, in my op	e, date an	d place, a	and due to the	cause(s date an	) and manner d place, and c	as sta	ed. he cause(s)	
	ro the within to the comple	Med	29b. Signature and	title of certifier	and mariner s	/	1	29c. License					te signed (Mo			
)			> Oes	cyl Heur	awij m	D (	B	- DO	059	47		i	1/71		25	
	6			ress of person who o		-	23 (Туре,	Print)						1		
			31. Date filed (Mor	DISHOD!	watsh	Ka	Cu	nberla	nd,	MD	2150	2				
	Sta Registr		,	10V 3 0 20	AU .	a a s signatu	k do	الثانية							1	

				For Stata Registrar	State of Marylan			of Health and of Death		iene g. No.	005	39231
	45	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Deat	Day.	Year	3. Time of Death
	allen Donas	/Medic	al	Jimmy Dean  4a. Facility Name (If not institution, give s.	Anders treet and number)	-	4b. City, T	own, or Location of Deat	December	T	2005 unty of Death	
		LXAIIIII	ाटा ः	Upper Chesapeake N	Medical Center	r	E	Bel Air		На	rford	
		Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. i	Vec	If Under 1 Months	Year If Under 24 Hrs Days Hours Min.	(Month, Day,	Year)		nplace (State or Foreign untry)
5		Director		215-36-8270 215-36-8270 Usual Residence of Decedent		65 115.			Dec. 26	,_193	9 Virg	jinia
7	0	Maryland	Ļ	10a. State 10b. County	10c. City	y, Town or Loc	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
3	5	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked othar than "naturel", or Iteme 23a or 28e-f ehow importent: if Item 27 is marked othar than "naturel", or Iteme 23a or 28e-f ehow important you other traumatic event, the Macinal Examinat must be notified at ance.	Funeral Director	Maryland Harford  10e, Street and Number	Be	el Air	10f. Zip (	Code	1	On Citizen	of What Cou	
7		s with the	Dir	2007 Highland Aver	1110		210			USA		
3		ome 23	nera		Was Decedent Ever in U.     Armed Forces?	S. 13. V		ent of Hispanic Origin? (S fy Cuban, Mexican, Puer	pecify Yes or No-	14.	Race - Amer Black, White	
न्त्र	36	s efter , or It	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		☐ Yes 2		,		ecify:	
Anders	5-0036	72 hours naturel', olcal Exe	ed b	15. Decedent's Educ	ation	16a. Deced	ent's Usual	Occupation		16b. Kind	of Business/l	<u>White</u>
	215	thin 72 9. an "na Madu	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give I	kind of work OO NOT use	done during most of wo a retired)	rking			
Dean	12121	filed within Hygiene. othar than "		12. Father's Name (First, Middle, Last)		El∈	ctric		ne (First, Middle, M			cation
2	and	d be fi	Be C	Andy Mack	Anders			Clara	Cora 1			.son
2	Maryland	should be and Mental is markad o sumatic eve	2	19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (	(Street and Number or Ri				
M		1 and 2 Health a lem 27 is		James K. Anders -				urch Drive,				
3	Baltimore,	Pages 1 and of He not: If Item		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re	20b. P emoval from State	lace of Disposementery, crem	sition (Name atory or off	e of her place)	Date	20c. Locati	ion - City or 1	Town, State
1.0	Ħ,	permit. Pages Department of Importent: If I any Injury or one		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		Air Me			07/05			
	Bal	Dermi Depa Impo any I		21. Signature of Funeral Service License	durde			okesbury Roa	McComas 1			
	4.6			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death			of dying, such as cardia	or respiratory arre		MOTATO	Approximate Interval Between
	100	Physician		Immediate Cause (Final disease or condition	Hy pertensue	arteri	asole	the Card	lisease	claw		Onset and Death
		/Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):						
		e de.	e	if any, leading to immediate	. Due to (or as a consequence	uence of):						
10	X	buted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
5	,00	tate be executed by sicien and the burial-transit	Exe	resulting in death) Last	Due to (or as a consequent	uence of):						
22	876	physic the b	dicai				-					
8/th 002/W	Box 68760,	The law requires that the death certificate the has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna					23d	. Date of delir	very
00	. B	death e atter	iciar	in the past 12 months?	1 Live birth 2 Feta 4 Pregnant at time of december 2		Ectopic pre Other (spe				Month	Day Year
2/	P.O.	of the	Phys	9 Unknown		. data in the contract of			OOD Did and			she cause of death?
~		signed by	þ	Part II. Other significent conditions con	ithbuting to death but not res	ulting in the un	iderlying ca	use given in Part I.	1 \( \text{Ye}		14.0	the cause of death?
	Records,	w require been si should?	Completed						24a. Was a			topsy findings available
>		The lar	omp						autops perforr	y	prior to c death? 1 ☐ Yes	ompletion of cause of
E	ita		BeC	25. Was case referred to medical examiner?				26. Place of De	ath (Check only on	/	1 1 1 1 1 1 1 1	230.0
mw	of Vital	Physician: this certific al director,	2	17 Yes 2 □ No		ER/Outpatien			dome 5 ☐ Reside			cify)
		ding Phys th. After this funeral di	tlon	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	M	3c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury or	ccurred	
8	Division	Atten or deal octor: by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, stre	et, factory,	office	28f. Location (St City or Town		lumber or Ru	ral Route Number,
de		itel or irs efte rai Dir led in		T I I I I I I I I I I I I I I I I I I I	Duilding, etc. (Opacin				Only or Ton	,, Oldio,		
Anders,		the Hospitel or Attending Physician: hin 24 hours efter death. the Funaral Director: After this certific inpletely filled in by the funeral director.	edicai	29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a restigation,	it the time, date and place in my opinion, death occ	e, and due to the caurred at the time, d	ause(s) and ate and pla	d manner as ace, and due	stated. to the cause(s)
		To the Hospitel or Attending I within 24 hours effer death. To the Funaral Director: Affer completely filled in by the funer	Med	29b. Signature and title of certifier	1			License number			igned (Month	
		.7		Fernand 1 MM	in MO, OME		De	014206	I	com	Cer 3	2005
		10		30 Name and address of berson who so	mpleted cruse of death (Iten	n 23a) (Type, I	70/8	164A BIRD	AVE I	BALTO	Md .	21223
	1	St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa		See of					

			For State Registrar	State of Ma		epartment Certificate					giene No.	05	39232
	Physici	an	1. Decedent's Name (First, Middle, Last	2)	-					2. Date of Dea Month	ith Day	Year	3. Time of Death
1	/Medic		Carl F. 13	artuck						12	04	Saci	1150 AM
4	Examin	ner	4a. Facility Name (If not institution, give	street and number)	0. HOD	4b. City,	Town, or	Location			4c. Cou	unty of Death	1
			5. Social Security Number 6. Se	X 7 Age	(In yrs. last birth	day) If Under	1 Year	If Under		9 Date of Birti	/	Q Birth	nplace (State or Foreign
	Funeral Director			<b>X</b> M 2□F	55 Y	Months	Days	Hours	Min.	8. Date of Birth (Month, Day DEC 29,	Year) 1949	Col	W York
			Usual Residence of Decedent							DEC 27,	1777	1110	WIOLK
	arylar ehow	_	MD Ba 1	Ltimore	10c. City, Town	or Location	D.o.	seda	.1.				10d. Inside City Limits
	18e-f	ecto		rrinore				seua	пе				1 ☐ Yes 2 XNo
	with ti	Funeral Director	1329 Pine Grov			10f. Zip		0100	7		10g. Citizen	of What Co	untry?
	eath	erai	11. Marital Status	12. Was Decedent Ev		13 Was Deced		2123	-	cify Yes or No-	14	USA Race - Amer	ican Indian
(0	r Hen	표	1 Never Married 2 Married	Armed Forces? 1 1 1 Yes 2 □ No		13. Was Deced If Yes, spec				Rican, etc.)	1	Black, White	
5-0036	ral', o	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:Vj	etnam	1 ☐ Yes 2	2 <b>⊠</b> No	Specify:			Spe	ecify: W	hite
2-0	n 72 hours after death with the Marylan "natural", or litems 23a or 28e-f ehow adical Exartifies mast ke notilited at	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	(	ecedent's Usua Give kind of wor	k done o	turina mos	t of workin	g	16b. Kind o	of Business/I	ndustry
121	within ne.	ш	Elementary/Secondary (0-12)	College (1-4or 5+		ife. DO NOT us	e retired . d e r	) -			Motol	Tobas	.cation
d 21	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Ifems 23a or 28e-f ehow ent, the Madical Examiner must be notified at	ပိ	1.7. Father's Name (First, Middle, Last)			WEI	uer		er's Name	(First, Middle,			.cation
an	d be ental ked o	To Be	Carl	Bart	ock					inces		DeRu	880
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic event, the Mi	-	19a. Informant's Name/Relationship (T)		_	Mailing Address	(Street a	and Numbe			r, City or To		
	1 end 2 Health a em 27 ls ther trai		Tammy C. Radtke	e, daught	er 132	9 Pine	Gr	ove	Ave.	, Ros	edale	e, MD	21237
ore	ges 1 end t of Health if item 27 or other tr		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ F	Compuel from State	20b. Place of Cometery,	Disposition (Name of crematory or of	ne of ther place	θ)	Da	ate	20c. Location	on - City or T	Town, State
<u><u>ĕ</u></u>	Pag ment ant: I		*4 ☐ Donation 5 ☐ Other (Specify)	•		Cremator	cy,	Inc.	12/0	6/05	Balt	imor	e, MD
Baltimore,	permit. Pages 1 end 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturany injury or other fraumatic event, Ita Madical Once.		21. Signature of Funeral Service Licens	George M	acNabb					of Mary Balti			21228
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	lications that caused the cause on each line	he death. Do no	t enter the mode	e of dying	g, such as	cardiac or	respiratory arr	est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cardi	ogenic	sh	ock						Onset and Death
	/Medical Examiner		resulting in dealth)		consequence of	):							
	10.0	i.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	consequence of	):	_			_			
	uted d ansit	Examine	Cause (Disease or injury										
o,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a	consequence of	):							
8760,	ate bys	Physician/Medical		d									
39	death certifica attending ph d for use as t	Med	IF FEMALE:										
Вох	ath couttend	ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death	3 □Ectopic pre					23d.	Date of delive	very Day Year
0	that the de ed by the a detached (	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tii 9□Unknown	me of death	5 Other (spe	ecity)						
۳.	res that the signed by be detact		Part II. Other significant conditions co	ntributing to death but	not resulting in t	he underlying ca	ause give	n in Part I.		23e. Did to	bacco use c	contribute to	the cause of death?
Records,	luires n sign lld be	d by	Lower extr	emity i	schenic	4				1 DY	5s 2 □ No	o 3 ☐ Pro	babiy 4 Unknown
Ö	w requir s been si should	lete								24a. Was a	ın 24	lb. Were aut	opsy findings available
Re	The tay cate has page 2	Completed								autops	ned?	prior to death?	ompletion of cause of
		Be C	25. Was case referred to medical					26. Place	of Death	1 ☐ Yes (Check only or	18)	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2 1110
of V	S D	일	examiner? 1 Yes 2 No	lospital:	2 ER/Outp	atient 3 DO	A Othe	r: 4 🗆 Nu	rsing Hom	e 5 Resid	ence 6 🗆	Other (Speci	ify)
	ding Ph h. After th funeral		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tin	ne of 28	Bc. Injury Work	at	2	8d. Describe h	ow injury oc	curred	
Sio	Attending r death. sctor: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be			М		/es 2 □!		at 1			
Division	i ji te	Certification;	4 Homicide determined	28e. Place of Injury building, etc.	y - At home, fam (Specify)	n, street, factory,	, office		2	8f. Location (Si City or Town	reet and Nu n, State)	imber or Hui	al Route Number,
_	spitel		29a. Certifier Programme Phy	sician: To the best of	my knowledge	death occurred a	at the tim	e date an	d place a	nd due to the c	ause(s) and	manner as	stated
	To the Hospitel or Attend within 24 hours after deati To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical Examione)	ner: On the basis of e and manner state	xamination and/	or investigation,	in my op	pinion, deal	th occurre	d at the time, d	ate and place	ce, and due	to the cause(s)
	withi To t com	Σ	29b. Signature and title of certifier				. License					ned (Month,	
				Lope	mo	A	441	1764	135-6	11801	12	14/0	5-
	Dri		30. Name and address of person who co	ompleted cause of dea	th (frem 23a) (T	ype, Print)	0 /0	510	and	R. 1.		04 1	2 /2 :
	0		31. Date filed (Month, Day, Year)	O CO	e Signatura	NUORE	TNE	JIK	447	DALL	MORY	MU	4120/
	Sta Registr			105 Sz. Augistrar	a Signature	park	,						
		2	DECAGE	January	-								

		For	State of Mary		artment o			, ,	2000	20000
<i>a b</i>		Registrar     Decedent's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	06	er illicate	oi Dealii	2. Date of			3. Time of Death
Physicia /Medic			William	Rober	t Bre	ngle	DEC	3 <sup>Da</sup>	2005	3:56 P M
Examin		4a. Facility Name (If not institution, give:			4b. City, Tov	vn, or Location		40	. County of Dea	
Funeral		101 Briarwood R  5. Social Security Number 6. Sep		n yrs. last birthday	/) If Under 1 Y			Birth		timore
Director		212-44-3173	<b>X</b> M 2□ F	59 Yrs.	Months D	ays Hours	FEB 2	Birth Day, Year) 4, 194	46 Ma	othplace (State or Foreign Country) aryland
and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or I	Location					10d. Inside City Limits
Maryl	tor	MD Balti	more		Dun	dalk				1 ☐ Yes 2 X No
ith the	Olrec	10e. Street and Number			10f. Zip Co			10g. Ci	tizen of What C	•
death with the Maryland ms 23a or 28a-f ehow Frant be nutting at	ral	101 Briarwood I				2122			US	
ING X IX IS-UUSO  be filed within 72 hours after death with the Marylar ltal Hyglene. d other than "natural", or frems 23a or 28a-f ehow event, the Macacal Examinat roam be notified at	Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ▼No	rin U.S. 13			igin? (Specify Yes or n, Puerto Rican, etc.	No-	14. Race - Am Black, Wh	
d Z IZ I 5-0050 filed within 72 hours after Hygiene. http://www.naturaf., or Ite ent, the Medical Examire	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 Tes 2 🕽	No Specity:			Specify:	White
n 72 h "natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Giv	edent's Usuai O re kind of work d DO NOT use n	one durina mos	t of working		ind of Business	s/Industry
i withir	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	ino.	Dispa	,		1	eel anspor	ctation
and and and and and and and and and and	BeC	17. Father's Name (First, Middle, Last)		'	отора		er's Name (First, Mic			
	Jo.	William Edg					Margare		Durr	
		19a. Informant's Name/Relationship (Ty Leah Brengle, w		4	Briarw		ar or Rural Route Nu	imber, City o la1k ,		Zip Code) 21222
ore, IN of Heelth fitem 27 or other tr		20a. Method of Disposition		20b. Place of Disc	The state of the s	of !	Date		ocation - City o	
Pages Pages nent o nery or		1 ☐ Burial 2 🖾 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Metro Cr	,		12/5/05	Ва	ltimor	ce, MD
Dalitimo permit. Pages Department of Important: If i eny Injury or once.		21. Signature of Funeral Service Licens	100				ciety of			
		George E. M  23a. Part1. Enter the disease, or compl				ACTOR DESCRIPTION			ımore,	MD_21228 Approximate
Physician		shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.				-	y an oot,		Interval Between Onset and Death
/Medical		disease or condition resulting in death)	Due to (or as a co	onsequence of):	1 con	CERN				MMONTY
Examiner	<u>.</u>	Sequentially list conditions,	Oue to (or se a c							
uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C00 to (0r 3e 3 c	unesquarios ory:						-
be executed cian and purial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
	dical		d							
death certificate e attending phys	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of p	pregnancy					23d. Date of de	alivory
death death e atter	Physician/Me	in the past 12 months?	1□Live birth 2 □ 4□Pregnant at tim	Fetal death 3	☐Ectopic pregn☐ Other (specif			_	Month	Day Year
that the de detached to	Phys	9 Unknown	9□ Unknown							
	by	Part II. Other significant conditions con	ntinbuting to death but h	ot resulting in the	underlying caus	e given in Part I		,		o the cause of death?  Probably 4 Unknown
Per requirement of the control of th	lete							Vas an	1	utopsy findings available
L e de de de de de de de de de de de de d	Completed						a	utopsy erformed?	prior to death?	completion of cause of
VICAL iclan: 1 certifical ector, p	BeC	25. Was case referred to medical examiner?				26. Place	1 □ Ye of Death (Check or		10.19	5 2U2 NO
2 t	ပ	1 ☐ Yes 2 No	lospital: 1 Inpatient	2 ER/Outpatie		Other: 4 Nu	ursing Home 5			ecify)
Jing Jing After fune	tlon	1 ■Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Y	ear) 28b. Time Injury		Injury at Work? 1 Yes 2		ibe how inju	ry occurred	
LIVISION I or Attending after death. Director: After din by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of fnjury building, etc. (	- At home, farm, s	street, factory, of	fice		on (Street ar Town, State		Rural Route Number,
urs after									·	
UNDSING To the Hospital or Attentivities 24 hours after deatl To the Funeral Director: completely filled in by the	edical	29a. Certifier 1	sician: To the best of mer: On the basis of ex and manner stated	amination and/or i	ath occurred at the investigation, in	he time, date an my opinion, dea	nd place, and due to th occurred at the tir	the cause(s ne, date and	) and manner a d place, and du	is stated. e to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	7 . A		29c. Li	cense number		29d. Da	te signed (Mon	th, Day, Year)
/		> Gr. Furtell	Stall P	Lynnon	01	9714		Dece	ember	5, 2005
15		30. Name and address of person who co		h (tem 23a) (Type	e, Print)	1/1 -	Dica Rais			. 12.24
Sta	ate	Michael Purtell 31. Date filed (Month, Day, Year)	, M.D. J/i		477 112	NIENT	Ave BALT	IMIR	1 M4	L/ L L 7
Registr		DEC 0 6 208	_	J. A.	024					

		1 - For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of F rtificate of a	lealth and I <i>Death</i>		giene () () Rog. No.	15 39234
Dhyoiai		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	ath Day	3. Time of Death
Physici /Medio		SHARON BLACKSTON					DEC	•	7:30PM
Examin	er	4a. Facility Name (If not institution, give s		*		r Location of Death	)	4c. County of	of Death
	×	SAINT AGNES 1				IMORE			
Funeral Director		220-80-7194	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day june 19	v, Year)	Birthplace (State or Foreign Country)     MD
pue *		Usual Residence of Decedent  10a. State 10b. County	10c Cib	, Town or Lo	cation				404 (- : - 0) ( : - 0
/anyl	ō	,	100. 01.9						10d. Inside City Limits 11 Yes 2 □ No
28a-	Director	MD 10e. Street and Number		B <i>P</i>	ALTIMORE 10f. Zip Code			10= Cities= -414	
with Se or	۵							10g. Citizen of W	,
death with the Maryland ms 23a or 28a-f ehow Frrust be ricitized at	Funerai	614 EDMONDSON AVE.	12. Was Decedent Ever in U.	S. 13. V	21228 Was Decedent of H	ispanic Origin? (Si	pecify Yes or No-	U.S.A.	- American Indian,
after or its	by Fur	1 XNever Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:	1	Was Decedent of H fYes, specify Cuba 1 ☐ Yes 2 🎛 No	n, Mexican, Puerti Specify:	Rican, etc.)	Specify:	k, White, etc.
72 hours natural',		15. Decedent's Educ	cation	16a. Deced	dent's Usual Occup	ation		16b. Kind of Bus	
hin 7:	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of wor	king	TOD: TAILE OF EAC	mios sindustry
d with giene er tha	E O	12	2	COSME	TOLOGIST			COSME	ETOLOGY
e file al Hy oth	ВеС	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Sumame	))
should b	0	ERNEST ROBINSON				NANCY H	ARRIS		
sho and lem		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, S	State, Zip Code)
end alth		DORIAN HARRIS/SON			EDMONDSON		ALTIMORE	, MD 212	28
permit. Pages 1 and 2 should be filed within pepartment of Health and Mental Hygiene. Important: If Item 27 le marked other than any Injury or other traumatic event. Item 00ce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	20b. Pi	ace of Dispo	sition (Name of natory or other plac	(a)	Date	20c. Location - C	City or Town, State
Pag nent ant: I		4 Donation 5 Other (Specify)	omovar nom otate		CEMETERY		-2005	Balto.,	MD
pparti		21. Signature of Funeral Service License	<b>*</b>		. Name and Addres	ss of Facility			
20129		My Mu		W1	206 W. No	Brown Co rth Ave I	Salto.	Funeral MD	Home P.A.
		23a. an1. Enter the disease, or come shock, or heart failure. List only on	carens that caused the death	. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	ISCHEMIC						Onset and Death
/Medical		resulting in death)	Due to (or as a consequ						5 DAYS
Examiner		Sequentially list conditions							
P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ianea of).					
ocute nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last							
e exe		resulting in death) Last	Due to (or as a consequ	ence of):					
icate be executed physicien and s the burial-transit	edicai								
் தால் ்	Mec	IF FEMALE:							
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year
at the	Phy	9 Unknown							
th se the igner	þ	Part II. Other significant conditions con	tributing to death but not resu	Iting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	oute to the cause of death?
plno s ues	ted						1 □ Y	es 2□No 3	B Probably 4 ☑ Unknown
as be	Completed						24a. Was a autops		ere autopsy findings available
The ate h page	5					-	perfori	med? de	ior to completion of cause of eath? □ Yes 2 □ No
stan: ertific ctor.	Be (	25. Was case referred to medicat examiner?				26. Place of Deal			3103 2 110
hysic his ce I dire	To	1 Yes 2 No		ER/Outpatien	t 3□ DOA Othe	er: 4 Nursing Ho	ome 5 Reside	ence 6 Other	(Specify)
ng P		27. Manner of Death 1 ☐Naturat 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			ow intury occurre	
endi eath. or: A	cati	2 ☐ Accident investigation				Yes 2 □ No			
r Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	eet, factory, office		28f. Location (St City or Town	treet and Number	r or Rural Route Number,
ital c rs af ral D									
he Hosp in 24 hou he Fune pletely fil	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Phys 2 ☐ Medical Examin	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and man ate and place, ar	ner as stated. Id due to the cause(s)
To the within 2 To the comple	Σ	29b. Signature and title of certifier			29c. License		2	9d. Date signed	(Month, Day, Year)
		Dr. hunnam			P10	1925		12/02/	2005
Λ		30. Name and address of person who co							
5		JYOTHI PUNNAM	, 900 S. CAT	ON A	VENUE,	BALTIMO	RE, MD	) -2123	19
Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signati		4				
Registr	ar	DEC 0 6 21	185 Maria	K. A	beater				

For Stete Registrer 1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie $\mathfrak{P}$ e0

Certificate of Death

2	0	2	2	C
U	7	6	J	J

Physician
/Medical
Examiner

2. Date of Death

3. Time of Death

**Funeral** 

Director

marked other than

Baltimore, Maryland 21215-0036

Pathent Known as Octa

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, certificate has been signed rector, page 2 should be del within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

Certification:

Medical

State

Registrar

Octa Briscoe							Novem	her	26	2005	04:30AN
4a. Facility Name (If not institution, give	e street and number,		4b. City,	Town, c	or Location				c. Count	y of Death	
Sinai Hospita	NOF Ba	ltimor	e Ba	thr	nor	e C	ity				
5. Social Security Number 6. S		ge (In yrs. last birt		r 1 Year	If Under		8. Date of I	Birth		9. Birthp	lace (State or Foreig
216-30-9036	□M 257 F	83	Yrs. Months	Days	Hours	Min.	Feb 1	Day, Year		Alaba	* .
Usual Residence of Decedent							ICD I	0, 1,	22	TTabe	ama
10a. State 10b. County		10c. City, Town	or Location							1	0d. Inside City Limits
MD		Ba1	timore								1√2 Yes 2 □ No
10e. Street and Number				Code				10g. C	itizen of	What Coun	itry?
2810 Suffolk Av	zenue.				212	15				ISA	
11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was Dece	dent of F			city Yes or	No.		ce - Americ	an Indian
1 ☐ Never Married 2 ☐ Married	Armed Forces	?	If Yes, spe	cify Cub	an, Mexica	n, Puerto I	Rican, etc.)		Bla	ck, White,	etc.
MD  10e. Street and Number  2810 Suffo1k Av  11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	If Yes, Give X Year or Dates:		1 Tes	2 <b>∏</b> №	Specify	:			Specia	bla	ck
15. Decedent's Ed	ducation	16a.	Decedent's Usu	al Occur	ation			16b. F	Cind of E	Business/Inc	dustry
(Specify only highest gra		5.1)	(Give kind of wo	ork done ise retire	<i>during</i> mos d)	st of workir	ng				•
Elementary/Secondary (0-12)	College (1-4or	D+)	dav	are	prov	ider			ch	ildre:	n
17. Father's Name (First, Middle, Last)						-	(First, Midd	lle, Maidei			unk
William Rabb											GIII
19a. Informant's Name/Relationship	Tyne Print)	19h	Mailing Address	(Stroot	and Numb	er or Rura	I Poute Nue	har Cihr	or Tourn	State Zin	Cadal
1			110000								21215
Renee Howard/nie	ce by mar		3626 W. Disposition (Na.	_	veder		ate	-		· City or To	
1 ☐ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☑ Other (Specify	Removalfrom State	cemeter	y, crematory or o	other pla	ce)		a.10	20c. L	ocation.	- City or 10	wn, State
21. Signature of Funeral Service Licen Ronald S.	Wade Dir	ector	State					I. Ba	1tin	nore S	treet
23a. Pax 1. Enter the disea A., or com	plications that cause	d the death. Do n	Baltim not enter the mod					arrest.			Approximate
show, or heart failure. List only	one cause on each I	ine.		,	0.		,				Interval Between Onset and Death
disease or condition resulting in death)	a Jeps	15									
f	Due to for as	a consequence of	of):								
Sequentially list conditions,	b										
cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of	SI):							-	
that initiated events	c										
resulting in death) Last	Due to (or as	a consequence o	of):								
	d										
IF FEMALE:					-						
IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2  Fetal death	2 🗆 🗆						23d. Da	ate of delive	ry
in the past 12 months?	4 Pregnant a		3 ☐Ectopic pa 5 ☐ Other (sp		<b>′</b>				Mo	onth	Day Year
9 Unknown	9□ Unknown										
Part II. Other significant conditions of	ontributing to death b	out not resulting in	the underlying o	ause giv	en in Part I		23e. Dio	tobacco	use con	tribute to the	e cause of death?
Find stage ren	ral dis	ease (	Corona	150	arte	54	1 [	Yes 2	DNo	3 Proba	ably 4 🗀 Unknown
discore di	0-100 10-	11.1.		7		-			-		
alsease, dias	sers me	11107	ypert	4751	ont		24a. Wa	opsy	24b.	Were autop	sy findings available reletion of cause of
Congestive h	east far	lure					per 1 ☐ Yes	formed? 2 D No		death?	212 No
25. Was case referred to medical examiner?				7			(Check only				
1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatio	ent 2 ER/Out	patient 3 DC	Oth Oth	er: 4 🗆 Nu	rsing Hom	ne 5 🗆 Re	sidence	6 Oth	ner (Specify,	(

1 🗌 Yes 27. Manner of Death 5 Pending investigation 1 Natural

2 🗀 Accident 3 🗀 Suicide

4 - Homicide

6 Could not be determined

DEC 0 6 2005

1 ☑npatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year)

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

mitra 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Replacement Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Amend Item 21 per DVR, 12/15/65 difficate of Death

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Physician LAIRE Guettner 4:20 pm NOL 2005 /Medical 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Nursing Haven Home Baltimore If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral**  Birthplace (State or Foreign Country) 1 M 2 1 F Hours 212 10 8370 Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or items 23a or 28e-f show the Medical Exerciment must be notified at ma 1 ☐ Yes 2 ☐ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3939 enhurst Are USA hours efter death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Avever Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: while \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 end 2 should be filed within 72 l Depertment of Health and Mental Hygiene. Important: if Item 27 Is marked other then "nett any injury or other traumatic event, the Medica 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 0 PBX Operator Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unk Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haven Hill Nursing Center 3939 Penhurst Avenue Baltimore, MD 21215
position (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Cher (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board, 655 W. Baltimore Street Ronald S. Wade, Director Baltimore, MD 21201 enter the mode of dying, such as cardiac o 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. or respiratory arrest, Physician Immediate Cause (Final disease or condition resulting in death) /Medical Cardiovascular Disease Examiner Due to (or as a consequence of): Examiner Dementia ng physician end es the burial-transit the Hospital or Attending Physicien: The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 perthyroidism Physician/Medical Due to (or as a consequence of): use ٥ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 3 Probably 4 Unknown 1 Yes 2 No ò 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? Completed hes 2KI No 1 ☐ Yes 2 PNo certificete 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Autonomin 24 hours efter death.

To the Funerel Director; After the Funerel Director of the fur 1 🕰 Natural 5 Pending investigation 2 Accident 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tertifying Physicien: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) moges 200 r 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gebremarian 4660 Wilkens Ave Belto Md 21229 Moges 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 1 5 2005 Registrar

			1 - For State Registrar	State of Maryla		partment of learning		nd Mer	ntal Hygien	0.05	39237
	Physici	an	1. Decedent's Name (First, Middle, Las	_		* *			Date of Death Month Da	ay Year	3. Time of Death
	/Medio Examir	cal	ANDREW  4a. Facility Name (If noninstitution, give	BRICE  Street and number)  SHISPHALM	ON Bab	4b. City, Town,	or Location of C		100.23	2005 c. County of Deat	11:30 PAM
	Funeral Director		5. Social Security Number 6. S 215-40-3921  Usual Residence of Decedent	ex	rs. last birthda Yrs.	Months Days		Min. Ma	Date of Birth Month, Day, Year ar 17, 19		hplace (State or Foreign untry) yland
	yiand		10a. State 10b. County	10c.	City, Town or	Location					10d. Inside City Limits
	e Mar	ctor	MD	В	altimor	e					1√7 Yes 2 □ No
	with th	Director	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Co	untry?
	eath v	Funeral	1243 Poplar Gro	ove Street  12. Was Decedent Ever in	IIS 13	Was Decedent of	2121		Ves or No-	USA 14. Race - Ame	dean Indian
920	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, it a Musical Examinations is exertified at	by	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates:	0.5.	. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Puerto Rica	n, etc.)	Black, White	
21215-0036	72 hc natur	Completed	15. Decedent's Ec (Specify only highest gra		(Giv	edent's Usual Occu re kind of work done	during most of	f working	16b. l	Kind of Business/	Industry
121	within ene. then	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)	life	disable	,				
d 2	other	Be C	17. Father's Name (First, Middle, Last)	0		uisabie		Name (Fil	st, Middle, Maidei	none n Sumame)	······································
Maryland	Mental Mental Arked o	To B	Andrew Bric	e			Le	ee Smi	Lth		
Man	2 should and Miles mark		19a, Informant's Name/Relationship (7	Type, Print)	19b. Ma	ling Address (Street	t and Number o	or Rural Ro	ute Number, City	or Town, State, 2	(ip Code)
	1 and 2 Health tem 27		Pamela Brice/sist 20a. Method of Disposition			Cedonia	Avenue	#B Ba			206
Baltimore,	t. Page rtment c rtant: if njury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🂢 Other (Specify	Removal from State	cemetery, cr	ematory or other pla				ocation - City or	
Ba	Depa Impo any is		21. Sign to Funeral Service Licen	Wade, Directo	-	22. Name and Addre tate Anat			55 W. Ba	ltimore	Street
	Physician /Medical		23a. Part1 Enter the disease, or confished or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Carhy	eath. Do not e	altimore, nter the mode of dy	ng, such as ca	rdiac or res	spiratory arrest,	tasis	Approximate Interval Between Onset and Death
	Examiner	niner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b Due to (or as a cons							
8760,	death certificate be executed e attending physicien end od for use as the burial-transit	icai Examine	that initfated events resulting in death) Last	c.  Due to (or as a cons d.	equence of):						
9	ntifica ing ph e as th	Med	IF FEMALE:								
P.O. Box	0 0	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у	-		23d. Date of deli Month	very Day Year
	The law requires thet the site has been signed by the bage 2 should be detache	by	Part II. Other significant conditions of	ontributing to death but not r	resulting in the	underlying cause gr	ven in Part I.		23e. Did tobacco 1 ☐ Yes 2	_	the cause of death?
Division of Vital Records,	Physician: The law r r this certificate has be aral director, page 2 sh	Completed						_	24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	prior to death?	topsy findings available ompletion of cause of 2 \( \sum \) No
ξ.	elclar certif irecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Ott	nor		eck only one)		
ō	Phy er this eral d	-	27. Manner of Death	1 Inpatient 2  28a. Date of Injury (Month, Day Year)	☐ ER/Outpation 28b. Time	SIL SELDON	4 🗆 Nursii		5 Residence Describe how inju		ufy)
sion	Attending Physician: r death. sctor: After this certifica by the funeral director. I	atio	1. ■Natural 5 □ Pending 2 □ Accident investigation		) Injury		rk? ]Yes 2∐No	1			
Dİ	i Die	Certification:	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Spe	ecify)				ocation (Street ar City or Town, State	9)	
	To the Hospitel within 24 hours of To the Funerel completely filled	edicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	ysician: To the best of my k illier: On the basis of exami and manner stated.	knowledge, dea ination and/or i	ith occurred at the ti nvestigation, in my o	me, date and popinion, death o	olace, and o occurred at	due to the cause(s the time, date an	) and manner as d place, and due	stated. to the cause(s)
	To the within To the comp	W	29b. Signature and title of certifier	, m Shah m	`?	29c. Licens		68	. 29d. Da	ite signed (Month	Day, Year)
			30. Name and address of person who of the control o	completed cause of death (It	SCC	Print)	pital	B	alhima	8 e . M	) 31113
DH	Sta Registr MH 17 Rev 1/2	ar	DEC C 20	sompleted cause of death (It	M A	arle)				ne en en en en en en en en en en en en e	

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 39238 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month NOVEMBER 28 2005 7:28 PM DAVID /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner HOSPITAL 9. Birthplace (State or Foreign Country) unk 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1**∑**M 2□ F Director 242-54-4969 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r then "natural", or items 23a or 28a-f ehov the Medical Experies must be notified at 1. Yes 2 No Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6000 Bellona Avenue 21212 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) Coltege (1-4or 5+) unk or other traumatic event, 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: if item 27 is marked oth eny linury or other traumatic event poice. 18. Mother's Name (First, Middle, Maiden Surname) unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5601 Locah Raven Blvd Baltimore, MD 21239 Good Samaritan Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □Donation 5 ♥Other (Specify) in state 21. Secture of Faheral Service Licensee Ronal S. Wa 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA Physician /Medical Due to (or as a consequence of): Examiner URINARY TRACT INFECTION Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. Certification: To Be Completed by Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ANEMIA 3 Probably 1 ∏Yes 2 ∏No CEREBROVASCULAR 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 2 No 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☑ 1No 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0061789 on-Awnely NOVEMBER 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LORRAINE OFORI-ANNAH, 5601 LOCH RAVEN BLUD. BALTIMORE NO 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 6 2005 CONSE! Registrar

State of Maryland / Department of Health and Mental Hygiene [] 5 State Registrar Amend Item # 20a-c&22 PER FIC 68560 a12 108 108 108 11 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Franklin Baker November 30, 2005 9:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Health Care of Hagerstown Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 🕅 M 2 🗆 F 217-32-4739 73 June 16, Director Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show 1 ☐ Yes 2√ No Washington Directo Hagerstown 10e. Street and Number 10g. Citizen of What Country? 10f, Zip Code 750 Dual Hgwy USA 14. Race - American Indian, Black, White, etc. 21740 Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 150-52 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2√ No Specify: white þ 3 Widowed 4 □ Divorced "naturei" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 12 0 <u>laborer</u> construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental is marked Franklin Eugene Baker Sr Edith Mae Shipley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Deborah Baker/daughter 28 Doe Drive McGaheysville, VA 22840 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of I Important: If it any injury or o Burial 2 Cremation 3 Removal from State Garrison Forest Vet. 12/12/05 Ocings Mills,Md. 21 Signature of Funeral Service Licensee Ronald S Wad 22. Name and Address of Facility J W Zumbrum F.H. State Anatomy Board Director mul -21201 6028 Sykesville Rd. Baltimore, MD 23a. ht1. Enter the disl as or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arreads, ock, or heart failure. List only one cause on each line. st Eldersburg in Appreximate 1784
Ship of the Consett and Death Immediate Cause (Final disease or condition resulting in death) **Physician** and dementa stage /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician and s the burial-transit To the Hospitei or Attending Physicien: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 0 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by server disorder ~ tensin 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1☐Yes 2☑No ို this i Director: After this id in by the funeral d 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funerel Direct completely filled in by 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30/05 D0062327 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Decreal Hanth, (Art of Marks to Wn) 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar DEC 0 6 2005

		_	For State Registrar	gg de Consti		iryland		artment of H rtificate of L			Reg. N	. 0 0 0		39240
	sicia edica		Decedent's Name     DIANA	e (First, Middle, La LEE BROW	•					2. Date of D Month DECEME	C	2, 200	еег 5	3. Time of Death  2:20 P.M
	mine			f not institution, given RESIDEN	re street and number)			4b. City, Town, or NOTTIN		eath		4c. County of B <b>ALTI</b> M		
Fune Direc			5. Social Security N 218-46-3	3972	Gex 7. Age 1 □ M 2 🖾 F	(In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of B. (Month, D. 12/20	irth lay Yea 0/19	60	Birthpla Count MARY	ace (State or Foreigr ry) "LAND
faryland show		'n	Usual Residence of 10a. State	10b. County  N/A			Town or Lo	RE CITY				<u>.</u>	10	d. Inside City Limits 1 XYes 2 No
r 28a-f		irect	MD 10e. Street and Nur	L		DA	TITINO	10f. Zip Code			10g. C	Citizen of Wha	at Count	
ath will		rai D	6117 MC	OYER AVEN	UE				206			USA		
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene is marked other than "natural", or Items 23a or 28a-f show surging and		by Funeral Director	11. Marital Status  1  Never Marri 3  Widowed	ied 2∭Married 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 █️No	spanic Origin? n, Mexican, Pu Specify:	? (Specify Yes or N uerto Rican, etc.)	0-	14. Race - Black, Specify:	White, e	
72 ho		Completed	(Spec	15. Decedent's E	ducation ade completed)		(Give	dent's Usual Occupa	furing most of	working	16b.	Kind of Busin	ess/Indi	ustry
should be filed within Mental Hygiene. marked other than		omo	Elementary/Seco		College (1-4or 5	+)		DO NOT use retired ISTRATIVE		TANT	M	EDICAL		
2 should be filed with and Mental Hygiene. Is marked other than		Be	17. Father's Name	(First, Middle, Last	)				18. Mother's I	Name (First, Middle	9, Maide	en Surname)		
hould to the marker		၉	RAYMOND  19a. Informant's Na		Tuna Printl		10h Mailie	ng Address (Street a		ABELLE SH			<b>7</b> :- 4	2-4-1
1 and 2 should 1 Health and Men Item 27 is marke				J. BROWN/				MOYER AV		BALTIMORE			-	J009)
permit. Pages 1 and 2 Department of Health a Important: If item 27 is			20a. Method of Disp		Removal from State	20b. Pla	ce of Dispo	sition (Name of matory or other place	θ)	Date	20c.	Location - Cit	y or Tov	n, State
t. Pag rtment			* 4 □ Donation	5 Other (Speci	(y)	PAR		CEMETERY		2/7/2005				
Depa Impo	Suc		21. Signature of Fu	Hu /	V. Hush		1 1	2. Name and Addres					L HO 2128	
			23a. Pirt1. Enter the shock, or hea	he disease, or con	plic vions that cause of one cause on each lin	the death.		The second secon				, ,		Approximate Interval Between
Physici	_	17	Immediate Cause ( disease or condition resulting in death)	(Final				alignont	. //					Donset and Death
/Medio Examir				ſ	Due to (or as a	a conseque	ince of):	0						,
D .5		ner	Sequentially list confidence in any, leading to improve cause. Enter Under Cause (Disease or	nditions, nmediate erlying	b. Due to (or as a	conseque	ence of):		-					
xecute		Examiner	Cause (Disease or that initiated events resulting in death) I	5	c. Due to (or as a	conseque	nce of):							
e be e		edicai E		l	d	,								
ing phy			IF FEMALE:											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the funeral prector: After this certificate has been signed by the attending physician and managed the funeral process of the purise of the human director and 2 should he detached for use as the humanist reast.		Physician/N	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)				23d. Date of Month		/ Day Year
v requires that been signed be detected by		ρ	Part II. Other signif	ficant conditions	contributing to death bu	t not result	ing in the u	nderlying cause give	on in Part I.		tobacco Yes 2			cause of death?
The law requale has been		Completed								24a. Was auto perfe		prior	r to com	sy findings available pletion of cause of
ysician: The is certificate ha		Be	25. Was case reference examiner?		Hospital:			• 3C DOA Othe	The second second	Death (Check only	one)	TT RES	STOE	NCE INN
g Phys	1	n: To	1 ☐ Yes 2 ☐ 27. Manner of Deatl		28a, Date of Injur	v 2	8b. Time of	3000	4   Nutsing	g Home 5 Res	idence	6 X Other (	Specify)	
ending Feath.		atio	1 Natural 2 Accident	5 Pending investigation		Year)	Injury		? ∕es 2□No					
To the Hospital or Attending Ph Wilhin 24 hours atter death. To the Funeral Director: Affar th		Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	building, etc	. (Specify)				28f. Location ( City or To	wn, Stai	te)		
ne Hosp n 24 hou he Fune		edical	29a. Certifier (Check only one)	1 Certifying Pl	nysician: To the best of miner: On the basis of and manner state	examinatio	edge, death in and/or inv	occurred at the tim vestigation, in my op	e, date and pla inion, death o	ace, and due to the courred at the time,	cause(s date ar	s) and manne nd place, and	or as stat due to t	ed. he cause(s)
To tl withi		Σ	29b. Signature and	title of certifier	tapull	20		29c. License	number			ate signed (N		
0	2		30. Name and addr	ess of person who	completed cause of de	eath (Item 2	3a) (Type,	Print) Wesn	hen Con	an Fretil	test.	ed for	1/2	Syen
,	Stat		31. Date filed (Mon	th, Day, Year)	32. Registra	r's Signatu	гө	3 Frankl	0	5/ 0.			- /	
Rec	jistra	=		DEC 0 6	2005	About &	G 1	wase!						

permit. Pages 1 and 2 should be filed within 72 hours after death v	Important: If itam 27 is marked other than "natural", or itsms 23s	any injury or other traumatic event, the Medical Examiner mus	Once.
Phy /N Exa	/sid led am		n al
ian: The law requires that the death certificate be executed	stificate has been signed by the attending physicien and	usit	

			1- State Registernend Item	State of Ma	aryland.	/ Depa	rtment of H	lealth ar		Hygiç	7005	e. 39241
79.	Physici		1. Decedent's Name (First, Middle CHARLES A. B	, Last)		<u> </u>	yny cheans or	Dealii	2. Date Mont DECEI		_	3. Time of Death 9:40 P. M
	/Medic Examin		4a. Facility Name (If not institution,		11.		4b. City, Town, o	r Location of [			4c. County of I	
	*	Kest.	STELLA MARIS H	OSPICE			TIMON				BALTIM	ORE
	Funeral Director	916	219-03-3486	6. Sex 7. Aga 1 1 1 2	e (In yrs. iast	t birthday) Yrs.	If Under 1 Year Months Days		Min. (Mon	of Birth th, Day, Y		Birthplace (State or Foreign Country)  NEW YORK
	land bw		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
	death with the Maryland ims 23s or 28s-f show if must be notified at	tor	MD BALT	IMORE	NOT	TINGH	ΔM					1 ☐ Yes 2 🙀 No
	or 28,	Director	10e. Street and Number				10f. Zip Code			10g	. Citizen of Wha	at Country?
	ath w		8241 POPLAR M			,	212				USA	
	Itsma Itsma	Funeral	11. Marital Status 1 □ Never Married 2 □ Marri	12. Was Decedent Armed Forces? ed 1 ☐ Yes 2 🔯 N		13. V	Vas Decedent of F Yes, specify Cub	lispanic Origin an, Mexican, F	n? (Specify Yes Puerto Rican, et	or No- c.)		American Indian, White, etc.
200	hours after tural', or Its	by	3 ₩ Widowed 4 Divorced	If Yes, Give Year or Dates:	40	1	□Yes 2□X%o	Specify:			Specify:	WHITE
2-0036	n 72 hours after death with the Manylan "natural", or Itams 23a or 28a-1 ehow salpal Exactinat musi ke notified at	Completed	15. Decedent' (Specify only highes	s Education t grade completed)	1	(Give	ent's Usual Occup	during most o	if working	16	b. Kind of Busin	
Z	t within 72 ho liene. r then "natui tre Medical	mpi	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. L	ONOT use retire	d)			ርጥለጥሮ ()	F MARYLAND
B	be filed v tal Hygie d other t	e Co	12TH GRADE 17. Father's Name (First, Middle, L	ast)		DIAI	IONALL E		s Name (First, M			r MARILAND
and	d la b	To B	CHARLES A. BUT						L CARRII		,	
ary	od 2 should lith and Men 17 is marke 17 is marke 18 is is is is is is is is is is is is is		19a. Informant's Name/Relationsh	tip (Type, Print)		19b. Mailin	g Address (Street	and Number	or Rural Route N	lumber, C	city or Town, Sta	ite, Zip Code)
Σ «`	s 1 and 2 if Health item 27		GEORGE A. BUTL	ER/SON		_	RICHARDS	ON ROAL			TER, MD	
saitimore,	permit. Pages 1 Department of H Important: If its any Injury or ot		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp.		cem	ROSA	sition (Name of natory or other pla RY CEMET	ERY   12		5 D	UNDALK,	
Rail	Depart Depart Import any Inj		21. Signature of Funeral Service L	N. Hac	w		Name and Address Name Address N					L HOME, P.A. 21286
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that caused only one cause on each in	the death. [	Do not ente	er the mode of dyir	ng, such as ca	ardiac or respirat	ory arrest	1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. INTERST	TITIAL	LUNG	DISEASE					Onset and Death
	/Medical Examiner		,	Due to (or as	a consequen	ice of):						
L	9	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequen	iea of):						
	cuted nd ransit	Examiner	that initiated events	с.								
, Q	le be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as	a consequen	ice of):						
789	physic	dical		d								
ROX	eath certific attending pl i for use as t	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of	f delivery
o.	The law requires that the death certificate te has been signed by the attending physoga 2 should be detached for use as the	Physician/Medi	in the past 12 months?  1 Yes 2 No 9 Unknown	1⊡Live birth 4⊡Pregnant at 9⊡Unknown			Ectopic pregnance Other (specify) _	<i>y</i>			Month	Day Year
S.	es that igned b be deta	by Pt	Part II. Other significant condition	ns contributing to death b	ut not resultir	ng in the un	iderlying cause giv	en in Part I.	23e.	Did tobac	cco use contribu	te to the cause of death?
Vital Records,	w require been sig should b								_	1 ☐ Yes	2 □ No 3 □	Probably 4 X Unknown
ပ္ပ	law rias be	Completed							24a.	Was an autopsy	24b. Wer	e autopsy findings available r to completion of cause of
工 ल		Con							10	performe res 2 <b>X</b>	d? deat	th? Yes 2□ No
Ž	sician certifi rector	Be	25. Was case referred to medical examiner?	Hospital:			_ Ott		f Death (Check			
	al d	To It	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Inju	ent 2□ER iry 28	b. Time of	28c. Injui	4 LINUISI			e 6 X Other (	Specify) HOSPICE
Division of	tending Flash. tor: After the funer	Certification:	1 XNatural 5 ☐ Pending 2 ☐ Accident investig		y Year)	Injury		rk? Yes 2∐No			, ,	
<u>N</u>	l or Atten aftar deat Director: in by the	tific	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ined   286. Place of Inj	ury - At home c. (Specify)	e, farm, stre	eet, factory, office		28f. Loca	tion (Street or Town, S	et and Number o	or Rural Route Number,
ā	urs afta real Dir led in											
	To the Hospital or Att within 24 hours aftar d To the Funeral Direct completely filled in by	ledicai	(Check only 2   Medical 8	g Physician: To the best Examiner: On the basis of and manner sta	f examination	idge, death n and/or inv	occurred at the tile restigation, in my o	me, date <i>a</i> nd popinion, death	place, and due to occurred at the	the caus	se(s) and manne and place, and	or as stated. due to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. Licens	e number		29d.		fonth, Day, Year)
	10	/		- 1-			DV	1372	5		12/5	105
1	1		30. Name and address of person v				,	TTMONT	IIW WD	21002		
€.	Sta	ite	31. Date filed (Month, Day, Year)	32 Pogists	are Cianatur	_		THUNT	UM, MD	21033	,	
	Registi	ar	DEC 0	6 2005	Eppend S	5 A	SEAL					
DH	MH 17 Rev 1/2	001		CARD.		Bar						

				epartment of Health and Me Certificate of Death		211115	39242
			Decedent's Name (First, Middle, Last)		Reg. 2. Date of Death		3. Time of Death
4	Physici /Medio		RUSSELL EDWARD BROTHERS		Month 11.28.20	Day Year	3:∞ P M
	Examin	er	4a. Facility Name (If not institution, give street and number)  MANOR CARE NURSING HOME	4b. City, Town, or Location of Death  CATONSVILLE		4c. County of Death BALTIMOR	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	HALL AND THE COLUMN	I. Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
	Director		Usual Residence of Decedent	's.   O	5.25.19	25	PA
	with the Maryland a or 28a-f show	'n	10a. State 10b. County 10c. City, Town				10d. Inside City Limits
	the Maryla 28a-f shor	Director	MD BALTIMORE RANDAL  10e. Street and Number	LSTOWN 10f. Zip Code	100	Citizen of What Cou	1 ☐ Yes 2 🛣 No
	23a or	al Di	3530 RESOURCE DRIVE # 115	21133	Tog.	USA	illuy:
	e	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Ameri Black, White,	
36	hours after tursi, or its al Examine	by F	1 □ Never Married 2 ⊠ Married 1 M2 Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:	1 ☐ Yes 2 🗷 No Specify:		Specify: BLA	
5-0036	72	eted	15. Decedent's Education 16a. I	Decedent's Usual Occupation (Give kind of work done during most of working	16b	. Kind of Business/In	
121	E	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)		PANSPORTA	2001
<b>d</b> 2	Hygi Hygi other	Be Co	12 7 U GRADE NA  17. Father's Name (First, Middle, Last)	18. Mother's Name (F	<del></del>		
Maryland 2121	2 should be and Mental is marked c	TOE	EDWARD BROTHERS	BESSIE	*****		
Mar	s 1 and 2 should f Health and Men item 27 is marks other traumatic			Mailing Address (Street and Number or Rural F  5 N. FELTON ST. PH	Route Number, Cit		o Code)
			20a. Method of Disposition 20b. Place of	5 N. FELTON ST. PH	-	. Location - City or To	own, State
Baltimore,	Pag nent ent: i		1 ❷ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Qonation 5 ☐ Other (Specify)	METHODIST CHURCH 12.03	3.05 ma	Jerionsvil	LE MD
Balt	permit. Depertr Imports sny inj		21. Signature of Funeral Service Licensee	VAUGHN C- GREENE FUN 5151 BALTO. NATU PIKE,	VERAL 8E	RNICE	
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	of enter the mode of dying, such as cardiac or n	respiratory arrest,	J 2122-1	Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition a. Eval Stray resulting in death)	larlanson's	Obsens	e (	In Known
1	/Medical Examiner		Due to (or as a consequence of	):			
	₽ #	ner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying	):			
_	be executed iclen and burial-transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	).			
8760,	cate be execu physiclen and the burial-tra	dical E	d	,			
9		Medi	IF FEMALE:				
Вох	death certifics e attending pl d for use as t	lan/	23b. Was decedent pregnant in the past 12 months?	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive	ery Day Year
P.O.	t the c	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	5 Utiler (specify)			,
	8 6 8	ρ	Part II. Other significant conditions contributing to death but not resulting in	he underlying cause given in Part I.		co use contribute to the	
Sorc	been	eted	CAO				bably 4 □Unknown
Vital Records,	e ie has je 2	Completed			24a. Was an autopsy performed	? prior to co death?	opsy findings available impletion of cause of
/ital	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?	26. Place of Death (C	1  Yes 2  ✓	No 1 □ Yes	2 No
o	Phys this ral dii	ို	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp			6 ☐Other (Specif	(y)
ion	ding After fune	atlon		me of ury 28c. Injury at 28c work?  M 1 ☐ Yes 2 ☐ No	d. Describe how in	ilury occurred	
Division	or Atter	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office 28f	f. Location (Street City or Town, St.	and Number or Rura	al Route Number,
Ω	lospital o hours af uneral Di uly filled in						
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Medical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occurred	d due to the cause at the time, date a	<ul> <li>(s) and manner as s and place, and due to</li> </ul>	stated. the cause(s)
	To t To t	Σ	29b. Signalure and title of certifier	29c. License number		Date signed (Month.	
	1/1	>	30. Name and addless of person who completed cause of death (Item 23a) (T	vpe. Print)		1 1/11/27	21208
0	<u>u</u>		Men Lett lema.	~ 1838 (Nees	e Tree	L Rd	21208
	Sta Registr		31. Date filed (Month, Day, Year) 32. Redistrar's Signature DEC 0 6 2005	Aires 1			
			January Jan				

			Please	Type or Prin	t in Bl	ack Indelib	le Ink.	Ensure A	II Copies	Are	Legible.	
			For	State of Ma	aryland				Mental Hy	giene	9	
			1 - State Registrar			Certifica	ate of L	Death	·	Reg No	005	39243
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month	aath Da	y Year	3. Time of Death
	/Medic	al	JEROLINE FAMH	BOOKER		45.03	T	1	DECEMI		1 2005	
	Examin	er	4a. Facility Name (If not institution, give Schad He	ospital of	Balti			Location of Death	Cilo	40	. County of Dea	
850	Funeral		5. Social Security Number 6. S		(In yrs. las	st birthday) If Uni	der 1 Year	If Under 24 Hrs.	8. Date of Bi	rth	9. Bir	tholace (State or Foreign
	Director		219.30.3715	□M 2 <b>⊠</b> F	70	Yrs. Month	s Days	Hours Min.	(Month, D.	103	5	mD
Ju21.	pu ,		Usual Residence of Decedent			T				,		
	anyta ahov	ä	10a. State 10b. County	000		Town or Location						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	ith the Marylar or 28e-f show	ecto	MD BALTIMO	KE	GWY	INN OAK	Zip Code			10- 0		
	72 hours after death with the Maryland natural', or itama 23a or 28e-f ahow deal Examine must be natified a	Funeral Director	5524 ROBINWOOD	AVENDE	_	101.	2120	7		Tog. Cit	tizen of What Co	ountry :
	ne 23	era	11. Marital Status	12. Was Decedent I		. 13. Was De	pedent of His	spanic Origin? (Si	pecify Yes or Ne	0-	14. Race - Ame	
9	or its	Ē	1 Never Married 25 Married	Armed Forces?	ło		1	n, Mexican, Puerti	o Rican, etc.)		Black, Whit	
5-0036	ral', c	d by	3 Widowed 4 Divorced	tf Yes, Give Year or Dates:		1 L Yes	20X No	Specify:			Specify: Bl	ACK
5-(	72 h natu	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Decedent's U (Give kind of	work done d	uring most of wor	king	16b. K	and of Business	/Industry
2121	within ene. then.	d L	Elementary/Secondary (0-12)	College (1-4or 5	+)	'iite. DO NOT BENEFITS	-	RPINATO	10	300	UAL SE	CHRITY
	Hygid Hygid Sther	ပို	17. Father's Name (First, Middle, Last)		1 2	DLIVEPITS	,	18. Mother's Nam				CURITY
an	iould be Mental narked o	То Ве	BENJARMIN NIC	HOLS				ROBERTA	POLLO	CY		
Maryland	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or itams eumatic avant, Ita Modical Examination		19a. Informant's Name/Relationship (			19b. Mailing Addre					or Town, State, .	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiens Itam 27 Is marked other than "natural", or itams 23s or 28e-1 show ther treumatic avant, its Medical Expression must be extilled as		G.MARCUS BOSTO	N (30N)	)	1 BALDW	N CT	. # B. (	CATONSV	ILLE	MD	21228
<b>Baltimore</b>	permit. Peges 1 and 2 Depertment of Health a Important: If Itam 27 is any injury or other tree		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	ce of Disposition (finetery, crematory of	lame of r other place		Date	20c. L	ocation - City or	Town, State
Ë	ment ment ant:		4 □ Donation 5 □ Other (Specifi		ARB	utus		12.00	1.05	BAL	MORE	MD
3a11	Depertition of the post of the		21. Signature of Funeral Service Licer	read .		VAUGH	and Addres	s of Facility	UNERAL	SER	CVICE	0.
	40344		Vang (	aliantian a that assumed	the death	ש וכוכ	440 K	HIC PIKE	BULTO .	עויי	21229	A
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	ne death.	Do not enter the if	oae or ayıng	, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Cara	liomyo	palh	4				
	Examiner			Due to (or as	a conseque	, 0	A	accide	ent			
轮		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a conseque	Vascul ence of):	US	acciae	(1) (			
	executed in and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
60,	be executed icien and burial-transit		resulting in death) Last	Due to (or as	a conseque	ence of);						
9289	ate be hysicie the bur	Completed by Physiclan/Medical	•	d								
9 ×	leath certificate b attending physic for use as the b	Med	IF FEMALE:	02- 11	-(							
Вох	attend for us	lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal d	leath 3 Ectopic					23d. Date of de Month	livery Day Year
P.O.	the d	ysic	1 □ Yes 2 ☑ No 9 □ Unknown	9 Unknown	time or dea	un 5 Other	(Specify)					
	w requires that the de been signed by the should be detached	y Ph	Part II. Other significant conditions of	onInbuting to death b	ut not result	ing in the underlyin	g cause give	n in Part I.	23e. Did	lobacco i	use contribute to	the cause of death?
rds	n sign	D D							1 🗆	Yes 2	□No 3MP	robably 4 Unknown
00	s bee	olete							24a. Was	an	24b. Were a	utopsy findings available completion of cause of
Re	The lavelete has	E O							auto perf	psy ormed? 2 No	death?	/
ita	ician: Th certificete rector, pag	Be C	25. Was case referred to medical					26. Place of Dea			) 10168	2 180 140
<u>_</u>		ToE	examiner? 1 ☐ Yes 2 ② No	Hospital: 1 ☑ Inpalie		R/Outpatient 3	DOA Othe	r: 4 🗆 Nursing H	ome 5 Res	idence	6 ☐Other (Spe	cify)
n o	ng Her Their		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year) 2	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe	how inju	ry occurred	
Division of Vital Records,	Attanding r death. sctor: After by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b			М		'es 2 □ No				
Νį	or At uffer d Direct in by	ıtıtı	4 Homicide determined	28e. Place of Injubulding, etc	ury - At hom c. (Specify)	ne, farm, street, fact	ory, office		28f. Location (	Street ar wn, State	nd Number or R e)	ural Route Number,
J	spital ours a neral i		29a. Certifier 1 Certifying Pr	ysician: To the best	of my knowl	ledne death occur	ed at the time	e date and place	and due to the	C2116-2/-	) and mass at	stated
	To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta	examination	on and/or investigati	on, in my op	inion, death occu	rred at the time,	date and	d place, and due	to the cause(s)
	within To th comp	Me	29b. Signature and title of certifier	2 4260-			29c. License	number		29d. Da	te signed (Mont	h, Day, Year)
	/-	-	I thena &	poleican	L		RES	-000		Dece	mber i	, 2005-
i	0	1	30. Name and address of person who			23a) (Type, Print)	, ,			110	( 0 = 0 : = 0	
					D,		HOSP	DITAL	OF B	celt-	cmore	
	Sta Regist		31. Date filed (Month, Day, Year)	2005 32. Registra	ai s signatu	A Down	0					

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## Statistics for increased and content of the cont	r	Physici	an	1. Decedent's Name (First, Midd			-				2. Date of Dea	ath	Year	
Union Memorial Nosaital  Sections  S	Ta.	/Medic	al					Ab Cha Tour	1	4 D15	- 1	per ol	2005	
Some interest   Some interes		Examin	er	· ` `		· ·		_		or Death		4c. Coun	NI/A	n
Description   Column   The Co		Funeral	2000	5. Social Security Number	6. Sex			If Under 1 Year	If Under		8. Date of Birt (Month, Da	h y, Year)	9. Birth	nplace (State or Foreign
The part of the		Director			1 L M 2 X	78	Yrs.							**
The process of the pr		yland		10a. State 10b. County		10c. C	•							10d. Inside City Limits
The process of the pr		Ba-f el	ctor		A 		Baltin	nore						1XXYes 2 □ No
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The process of the pr	36	s after death , or Iteme 2	y Funera	1 Never Married 2 Mar	ried 1 Tyes	Forces? 2 ☑ No Sive		If Yes, specify Cub	an, Mexicar	gin? (Spe n, Puerto I	ocify Yes or No- Rican, etc.)	Bia	ack, White	e, etc.
Elementary/Secondary (0-12)   College (1-4of 5+)   Bar Tender   Ilospitality	9-0	2 hour	ted t	15. Deceder	nt's Education		16a. Dece	dent's Usual Occur	pation	. ,				
The proposed of the proposed o	218	ithin 7	npie	Elementary/Secondary (0-12)			life.	DO NOT use retire	d)	t of workir	ng		7.	
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The part of the pa	lary	2 should be and he man				1 - 1 1							n, State, Zi	ip Code)
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Physician (Indexical Examiner Physic	imor	Pages ment of ant: If It		1 ☐ Burial 2 ☑ Cremation		n State	cemetery, crei	matory`or other pla						
Physician (Medical Examiner)  The proposal and address Cause (Final Face of Cause (Final Face))  The proposal and address cause (Final Face)  The proposal face of Cause (Final Face)  The proposal face	Balt	permit. Departimport Import any inj		Kin	201/	uss)	F	urgee-He	nss-Se	itz	Funeral	l Home,	Inc.	21211
Physician (Medical Examiner    Medical Examiner				23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that t only one cause on	caused the dea	th. Do not ent	er the mode of dyir	ng, such as	cardiac o	r respiratory ar	rest,	1ano	Interval Between
Due to (or as a consequence of):    Chronic Obstructive Pulmonary Disease   20 years				disease or condition										n 1
The part of the pa				rossining in assum,				0.1		D.'				4800
Section   Sect			ner	Sequentially fist conditions, if any, feading to immediate cause. Enter Underlying	b. Due to	o (or as a conse	DS COULT	The rum	onary	Dise	ease			20 years
Section   Sect		acuted and transi	ami	that initiated events	) c	TN								20 years
FFEMALE:   23b. Was decedent pregnant in the past 12 gronths?   1   Yes   2   Moo   2   Moore   1   1   Live birth   2   Fetal death   3   Ectopic pregnancy   1   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Moorth   Day   Year   4   Moorth   Day   Moorth   Day   Year   4   Moorth   Day   Year   4   Moorth   Day   Moorth   Day   Moorth   Day   Moorth   Day   Moorth   Day   Moorth   Day   Moorth   Day   Moorth   Day   Moorth   Day   Moor	60,	be ex sicien a burial	ai E)	lossing in dounty 2001				diconse	,					10 1122 5
The second of the second program of the seco	687				d. Cei	ISDIO ACTZ	Cuar	CAI SEU SC						10 gears
The standing of the control of the cause of death?    1   Yes   2   No   3   Probably   4   Munknown	Box	0 0	ysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No	1 ☐ Live 4 ☐ Prec	birth 2 ☐ Feta gnant at time of o	al death 3[		у					
25. Was case referred to medical sexaminer?  1   Yes   2   No  27. Manner of Death   1   No   No    28a. Date of Injury   28b. Time	<u>a</u>	s that produced by		Part II. Other significant conditi	ons contributing to	death but not re	sulting in the u	nderlying cause giv	en in Part f.		23e. Did to	bacco use con	tribute to	the cause of death?
25. Was case referred to medical sexaminer?  1   Yes   2   No  27. Manner of Death   1   No   No    28a. Date of Injury   28b. Time	ord	equire sen sig ould b									1 🗆 Y	'es 2□No	3 ☐ Pro	bably 4 Munknown
The state of the s	al Reco		Comple								autop	med?	death?	ompletion of cause of
The state of the s	Vita	sician certifi irector	80	examiner?	Hospital:	36	7.500	Oth	or					
2   Accident 3   Suicide 4   Homicide   Size of Injury - At home, farm, street, factory, office   28t. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifier   12   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29b. Signature and title of certifier   29c. License number   29c. License number   29d. Date signed (Month, Day, Year)   29c. No. D   AT 2438946-F6   December, 1, 2005   29c. No. D   21218   29c. No. D   20c. No. D   20c. No. D   20c. No. D   20c. No. D   20c. No. D   20c. No. D   20c. No. D   20c. No. D   20c. No. D	of		$\vdash$	27. Manner of Death	28a. Date	of Injury	28b. Time o	" 3DDON	4 🗆 140					ify)
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29a. Certifier (Check with one)  29a. Certifier (Check with one)  29a. Certifier (Check with one)  29a. Certifier (Check with one)  29a. Certifier (Check with one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  WALID BARBOUR, Union Memorial Hospital, Baltimore, MD 21218	Divi		Sertific	data	nined 288. Plac	e of Injury - At h ding, etc. (Speci	nome, farm, str fy)	eet, factory, office		2	8t. Location (S City or Tow	Street and Num n, State)	ber or Rui	ral Route Number,
2 M.D AT 2438946-F6 December, 1, 2005  WALID BARBOUR, Union Memorial Hospital, Baltimore, MD 21218		d hour		(Uneck only 2   Medical	Examiner: On the	pasis of examina	owledge, death ation and/or in	h occurred at the tir vestigation, in my o	me, date an opinion, deal	d place, a th occurre	and due to the ded at the time, o	cause(s) and m date and place,	anner as :	stated. to the cause(s)
2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WALID BARBOUR, Union Memorial Hospital, Baltimore, MD 21218		To th withir To th comp	Me	29b. Signature and title of certifie	er /	Sen.						29d. Date signe	ed (Month,	, Day, Year)
2 WALID BARBOUR, Union Memorial Hospital, Baltimore, MD 21218	)	~	1		6		M.[		24389	46-F	6	Decem	ber, i	, 2005
	1	5							ultimo	re, N	10 2121	8		
			13	31. Date filed (Month, Day, Year,					-TWITTE	, .	ا سه استد سه ر			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) 20ŎS **Physician** Backus Gertrude Rose 6;00P December /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examinér 1425 Roland Heights Avenue Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2<del>√</del>XF Yrs. 218-40-4721 23. 1910 **Director** Virginia Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-f show any injury or other treumatic event, If I Marical Employment. 10c. City, Town or Location 10d, Inside City Limits 10a State 10b. County 1 Yes 2 No N/A Maryland Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1425 Roland Avenue 21211 USA Funerai 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes A No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Leonard Wolf Unknown ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/19a. Thomas Backus Informant's Name/Relationship (Type, Son 1425 Roland Heights Avenue, Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 Cremation 3 Removal from State Meadowridge Memorial 12/8/2005 Dorsey, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Burgee-Henss-Seitz Funeral Home, Inc. 21211 21. Signature of Funeral Service L 3631 Falls Road, Baltimore, Maryland 23a. Part1. Enforthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (pr as a consequence of): disease or condition resulting in death) year /Medical Examiner rehuvas cellar years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transil been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 Live birth 2 Fetal death Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) I Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 XXIO 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: ector, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 \_\_ Inpatient Other: 4 Nursing Home 217 No Certification: To 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) funeral dir 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending 1 Yes 2 \ No death. investigation the f Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide after pelil within 24 hours To the Funerel 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10 12-5marquet mileir 6620 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3350 出 8  $\infty$ 0 31. Date filed (Month, Day, Year) Registrar's Signature State DEC 0 6 2005 Registrar

			1 - For State Registrar	State of Maryl		artment of rtificate o		Mental Hy	giene	)5 (	39246
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	/Medic Examir		4a. Facility Name (If not institution, give	,			n, or Location of Dear	1100	4c. Cour	nty of Death	3000
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	with the Maryland t or 28a-f show be notified at	Director	10a. State 10b. County  Maryland Baltimo  10e. Street and Number		City, Town or L Baltimor		0		10g. Citizen d		0d. Inside City Limits 1 ☐ Yes 2 No try?
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1	Sta Registr	te ar	29b. Signature and title of certifier  Co. Ray 1  30. Name and address of person who co  W. RAYMOND ZHU  31. Date filed (Month, Day, Year)  DEC 0 6	, MD. DEPT	PATHOL	OGY ST	T.AGNES HO	OSPITAL.	900 (ATO)	N ÄVE,	MO31274

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			For	State of Marylan	nd / Depart	tment of	Health and I	•	_	e. 5 39247
			1 - State Registrar		Certi	ficate of	Death	,	Reg. No.	) 33641
	Physici /Medi		1. Decedent's Name (First, Middle, La Virginia Grayce B	Brown				2. Date of De Month	_	3. Time of Death
	Examir	ier	4a Facility Name (If not institution, giv	e street and number LCA	/ 4	111	or Location of Deatl	n	4c. County of	Death /
	Funeral		5. Social Security Number 6. §	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days		8. Date of Bird (Month, Da	th y, Year) 9	Birthplace (State or Foreign Country)
1-9	Director	Ì	Usual Residence of Decedent	8	7 115.			2-18-	1918	NY
	Maryland f ehow	٥	10a, State 10b. County		ty, Town or Local					10d. Inside City Limits 1 ☐ Yes 2 🎮 No
T.	28a-	Funeral Director	MD Anne Ar  10e. Street and Number	undel G	len Bur	nie 10f. Zip Code		1	10g. Citizen of Wha	it Country?
9	h with	a Di	13 Birch Avenue			21061			U.S.A	,
T.	deat	ner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13. Wa		Hispanic Origin? (S ban, Mexican, Puert	pecify Yes or No		American Indian,
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≥ A	and A	-	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailing	Address (Stree	at and Number or Ru	ral Route Numbe	er, City or Town, Sta	te, Zip Code)
3 ₹	and and mark		Terence C. Brown				.; Glen B		1D 21061	
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	/Medical		resulting in death)	Due to (or as a conseq	uence of):					
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ĺ	7		30. Name and address of person who			•				
	V S	•	Dr. Tsion Behane 31. Date filed (Month, Day, Year)	301 Hospital	Drive;	Glen Bu	rnie, MD	21061		
	Sta Registr		DEC 0 6 200!	32. Registrar's Signa	Locale					

			State of Maryland / Department of Health State   State			2005	39248
Ą			1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medio	2	ROBERT CHARLES BENJAMIN		Month December	2, 2005	9:10 P <sup>M</sup>
	Examin	4	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Lo	ocation of Death		4c. County of Dea	
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3.,	Funeral		1N/M 2 T E Months Days	Hours Min.	8. Date of Birth (Month, Day, Y		thplace (State or Foreign ountry)
145	Director		219-01-1821 86 Yrs.		June 3,		aryland
	and		Usual Residence of Decedent				10d. Inside City Limits
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	n the Maryland r 28a-f show	Director	Maryland Baltimore County Timonium  100. Street and Number 101. Zip Code		100	. Citizen of What Co	
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פ	be filed ital Hygi d other event.	Be	17. Father's Name (First, Middle, Last)	8. Mother's Name	(First, Middle, Ma		
<u>lan</u>		10	Oscar R. Benjamin	Mahe1	LaRue		
Mary	s 1 and 2 should f Health and Men item 27 is marke other treumatic	ļ .	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	d Number or Rura		ity or Town, State,	Zip Code) 21093
	and 2 ealth n 27 i	1	Mary M. Joan Benjamin (Wife) 210 Belmont Fo	wort Cor	rt #105	Timoniae	Maruland 2
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			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, s	such as cardiac o	r respiratory arrest	Maryland	Approximate
	Physician		shock, or heart failure. List only one cause on each line, Immediate Cause (Final				Interval Between Onset and Death
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á	afte Dire	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, S	state)	
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	withir To th comp	Me	29b. Signature and title of certifier 29c. License n	umber	29d	. Date signed (Mon.	th. Day, Year)
}			DE SIL	7732	1	ke 5, 2	2005
	1-1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
F	1 '		GAM CONON, MO 6,69 N. CHAMOST	· 11	trano.	NE, MD.	21204
7	Sta	ate	31. Date filed (Month, Day, Year)  32. Refistrar's Signature				
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		State of Maryland / Department of Health and N State of Maryland / Department of Health and N Certificate of Death		ene 9. No. 0 0 5	39249
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/Medica Examine		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	NOVERDE	4c. County of Dea	
		Anne Arundel Medical Center Annapolis  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne A	
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	0		Claggett		
C = 0 F		19a. Informant's Name/Relationship (Type, Print)  Mary A. Henriques(Sister)  1408 Regent St. Ann			
altimore, mit. Pages 1 ar partment of Hea portant: If item y injury or othe	i			0c. Location - City or	
Baltimori permit. Pages Department of P Important: If ite any injury or of once.		'4 □Donation 5 □Other (Specify) Gardens 12-5		Annapolis	
Departr Departr Importa any inje		21. Signature of Funeral Service Licensee  **Min. Reese of Eacily on S  **Each Service Licensee  **Win Name and Address of Eacily on S  821 West St. Ann.	Mortua apolis,	Md. 21	101
The state of		23a. Part1. Enter the 3 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a			dirings
Examiner					
nsit .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
8760, cate be executed by sician and the burial-transit		that initiated events ' c C			
	dical	d			
BOX 6  Geath certific attending p	ician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of de	livery
o death	hysicia	in the past 12 months?  1 Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify)		Month	Day Year
that the de ned by the additional	۵.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
COTGS, Power requires that is been signed to should be det	ted by	Cardionyopathy	1 🗆 Yes	2 <b>Ø</b> No 3 □ P	obabiy 4 Unknown
The law requires to the has been signed page 2 should be considered.	Completed	Diabetes he ditis	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
	0	25. Was case referred to medical 26. Place of Death	Yes 2	□No 1□Yes	21 <b>2</b> No
thys this state of the state of	TOB	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther. 4 Nursing Ho		The state of the s	cify)
on conding Figure 1. After of funeral	tion:	27. Manner of Death  1	28d. Describe how	v injury occurred	
LIVISION  I or Attending after death. Director: After in by the fune	Certification:	2 Suicida 6 Could not be	28f. Location (Stre City or Town,	et and Number or Ri	ural Route Number,
pital o					
To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and place, and manner stated.	and due to the cau ed at the time, dat	ise(s) and manner as e and place, and due	to the cause(s)
To t Com	Σ	29b. Signature and title of Certifier  Du6052		d. Date signed (Mont	
2.		30. Narpe and address of person who completed cause of death (Item 23a) (Type. Rgint)		11-26-0	*
Y\		Spoince Bech, to 2001 Medical Parkway, annat	riss , th	) -	
State Registra	e Ir	30. Name and address of person who completed cause of death (Item 23a) (Type, Brint)  Siverical Brint, Typ 2001 William (Annua)  31. Date filed (Month, Day, Year)  DEC 0 6 2005			

			For State Registrar	State of	Maryland / D	epa Cert	rtment of He	ealth a Death	and M		gierre ()	05	39250	
	R.		1. Decedent's Name (First, Midd	e, Last)						2. Date of Dea	ith		3. Time of Death	
	Physicia /Medic		JOSEPHINE	GATEWOOD (	CAMPBELL					Month Novembe	Day r 30	Year 2005	0418 a <sup>M</sup>	
	Examin		4a. Facility Name (If not institution	n, give street and numb	oer)		4b. City, Town, or	Location of	of Death		4c. Cou	nty of Death		
****		44	BON SECOUR	HOSPITAL			BALTIN					N/A		
· . *	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birtl		If Under 1 Year Months Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day			place (State or Foreign intry)	
	Director	į.	212-36-7396	10 101 2021	76 Y	rs.				Nov 19	1929	PHI	LIPPINE	
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Loc	ation						10d. Inside City Limits	
	Mary -1 • ho	ō	MARYLAND N/	7.	BAL	m T 1/4/	ODE						1⊈Yes 2□No	
	28a	Director	10e. Street and Number	<b></b>	DAL	TIM	10f. Zip Code				10g. Citizen	of What Cou	intry?	
	3a o		2 N SMALLWOOD	STREET AF	РТ 137		21223				11 C	.A.	•	
	deatl	by Funeral	11. Marital Status	12. Was Deced	ent Ever in U.S.	13. W	as Decedent of His Yes, specify Cubar	spanic Orig	gin? (Spe	cify Yes or No-		Race - Amer		
9	or its	T.	XXNever Married 2 ☐ Mar	Armed Force	TX No		Yes, specny Cuban □Yes 2 No	Specify:	, Puerto I	rican, etc.)		Sfack, White	, etc.	
8	inei',		3 Widowed 4 Divorced	If Yes, Give Year or Date	es:		L 163 2 140	эрвспу.			Spe	cify: FI	LIPINO	
7	within 72 hours after death with the Maryland ene. Than "naturel", or iteme 23a or 28a-f ehow te McJical Exactions must be coldied at	Completed		t's Education st grade completed)		(Give k	ent's Usual Occupa and of work done do	urina most	t of workii	ng	16b. Kind o	f Business/Ir	ndustry	
2	within the or th	ф	Efementary/Secondary (0-12)	Coflege (1-4	or 5+)		O NOT use retired)							
2	filed y Hygie Sther i		GED  17. Father's Name (First, Middle,	(ast)		DIE.	rician	18 Mothe	r's Name	(First, Middle,		OOL C	AF'E	
	ontal	Be c		ŕ								allie)		
<u> </u>	should nd Men marke umatic	P	P HENRY M CAMPBELL LOUISA E GAT  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Numb											
<u> </u>	and 2:		Josephine Sha	v/Daughter			Guilford							
ā,	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  If of Health and Mental Hygiene.  If men 27 is marked other than "naturel", or iteme 23a or 28a-1 show or other traumatic event, the Medical Examinat market and filed at		20a. Method of Disposition		20b. Place of	Disposi				ate	20c. Locatio			
Ë	Pages nent of int: if it iny or o		1X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		ate		DRAL CEM.	1	12-06	5-05	3 T.TTM	OPF 1	MARYLAND	
Baltimore,	그 문문을 .		21. Signature of Funeral Service	License	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	22.	Name and Address	s of Facilit	у					
<u> </u>	Depa Impo eny is		- Wallanu	CA		120	LLIAM C B	H AV	ENUE	AUNITY I	UNERA	L HOM	E P.A.	
* .	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	ised the death. Do no	ot enter	the mode of dying	, such as	cardiac o	r respiratory ari	est,		Approximate Interval Between	
			Immediate Cause (Final disease or condition resulting in death)  a. Benal failure  Due to (or as a consequence of):										Onset and Death	
												1		
		١	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury)									years		
	nsit	nine										(		
	al-trar	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):											
8760	cate be executed bhysicien and the burial-transit	dicai E												
89	ificate g phy as the	edic		30.										
Вох	eath certific attending pl	In/M	IF FEMALE:  23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy								23d. Date of delivery			
	ed for	sicie	in the past 12 months? 1 Yes 2 No		nt at time of death		Other (specify)					Month	Day Year	
0.0	at the	Certification: To Be Completed by Physician/Me	3 Li Otikriown											
Ś	The law requires that the death certific lie has been signed by the attending p bage 2 should be detached for use as i		Part fl. Other significant conditi	ons contributing to dea	Λ ' \			n in Part I.			_	use contribute to the cause of death?		
0	w requir been si should		coronary certery disease 10 Yes							es 2□No	2 No 3 Probably 4 □Unknown			
ec	e taw has b je 2 sl									24a. Was a autops	SV	prior to co	opsy findings available impletion of cause of	
<u>=</u>										perfor	ned? 2 No	death? 1 ☐ Yes	2 <b>55</b> No	
=======================================	sician: Th certificete rector, pag		25. Was case referred to medica examiner?	Hospital:			Other	_		(Check only or				
ō	Phys		1 ☐ Yes 2 No  27. Manner of Death	28a. Date of			3 DOA 28c. Injury Work	4 I Nursing Hor	ne 5 Residente R			(y)		
5	tending Physician: The leath. tor: Affer this certificete hi the funeral director, page		1√∑Natural 5 Pending (Month, Day Year) Injury W						Work?			urrod		
Division of Vital Records,	i or Attending Physician: after death. Director: After this certifice in by the funeral director,	Ifica	3 Suicide 6 Could	not be 28e. Place of	Injury - At home, far	m, stree	et, factory, office		2	8f. Location (S	treet and Nu	mber or Rur	al Route Number,	
ā	safte safte al Dir	Sert	4 Homicide building, etc. (Specify)								n, State)	State)		
	hour uner uner sly fills	edicai	29a. Certifier 1 Certifying (Check only 2 Medical	ng Physician: To the b Examiner: On the bas	est of my knowledge,	death o	occurred at the time	e, date and	d place, a	nd due to the c	ause(s) and	manner as s	itated.	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medi	One)	and manne	r stated.				00001119					
	5 1 × 1 × 2	-	29b. Signature and title of certifie	Co.	4		29c. License			1	9d. Date sig			
		,	poula	no zuis	ט		D463	55 /			HCLI	mper	2,2005	
1)			J. OM chony	who completed cause	of death (ftem 23a) (1 30) ST Pau			7010	(-	3a(+)	V A 1	WA	21202	
	Sta	te	31. Date filed (Month, Day, Year)	1 /	istrar's Signature	· · ·	s well	100	1	Jac 113	rev		-1202	
100 m	Registr		DEC 0	6 2005	sever &	A STATE OF	exter							

				State of Maryla	and / Depa		alth and M	ental Hygie	•	39251	
_		Physicia /Medic	al	1. Decedent's Name (First, Middle, Last) Eileca Conlog a				2. Date of Death Month	Day Year 28 200		
		Examin Funeral Director	ier	066-30-9736 1□M 2⊠F 6	Yospik) yrs. last birthday) 7 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	4c. County of Dea (ear) 9. Bi 1938 Ne	ath  Inthibiace (State or Foreign ountry)  W York	
Condayan		permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural", or itama 23a or 28a-f show any injury or other traumatic event, I'm Medical Examiner must be notified at once.	ctor	Maryland Howard	. City, Town or Loc	cation				10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	Baltimore, Maryland 21215-0036		Funeral Director	10e. Street and Number 11915 Hampstead Green 21042				10g	10g. Citizen of What Country? U.S.A.		
			by	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	1		Specify:		14. Race - Am Black, Wh Specify:		
			Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)		dent's Usual Occupation kind of work done duri DO NOT use retired) Homemaker	on ing most of workin	16	6b. Kind of Busines:	Home	
			To Be (	17. Father's Name (First, Middle, Last) Charles Ferguson			Anne McG		,		
				19a. Informant's Name/Relationship (Type, Print)  John Condayan (husband)  20a. Method of Disposition	11915	ng Address (Street and Hampstead sition (Name of matory or other place)	Green	Ellicott		ryland 21042	
				I Dullat 2 2 Cremation 3 Dremoval noin State	Metro Cr	ematory	12-1- of Facility ral_Home			Maryland vland 21045	
	Division of Vital Records, P.O. Box 68760,		Physician/Medical Examiner	23a. Part1. Enter the disease, or complications that aused the dishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uis ass or highly that initiated events resulting in death) Last  Due to (or as a constitution of the cause).  Due to (or as a constitution of the cause).  Due to (or as a constitution of the cause).	death. Do not enter sequence of):  M2 4/4		such as cardiac o	r respiratory arres		Approximate Interval Between Onset and Death	
				IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ☑ No 9 □ Unknown  23c. If yes, outcome of pre 1 □ Live birth 2 □ F	Fetal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	blivery Day Year	
			by	Part II. Other significant conditions contributing to death but not As to Myocardial Tofarction,	44	nderlying cause given i	in Part I.	1		o the cause of death?	
			e Completed	Acute live Forluse ( Overian Comce- 25. Was case referred to medical	Cougaly.	d' c		24a. Was an autopsy performe	prior to death? ∃No 1 ☐ Ye	utopsy findings available completion of cause of s 2 140	
1# 1			Certification; To Be	examiner? 1							
K pervi				1 Autural 5 Pending (Month, Day Year) Injury Work? 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 6 Homicide 6 Could not be building, etc. (Specify) 1 Injury Work?  M 1 Yes 2 No  289. Place of Injury At home, farm, street, factory, office building, etc. (Specify) 289. Place of Injury At home, farm, street, factory, office City or Town, State)							
10			edical C	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my one)  2 Madical Examinar: On the basis of exam and manner stated.	knowledge, death nination and/or inv	n occurred at the time, vestigation, in my opini	date and place, a ion, death occurre	nd due to the cau ad at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)	
			2	29b. Signature and title of Certifier	17	29c. License n		29d	Date signed (Mon	th, Day, Year)	
			ate	30. Name and address of person who completed cause of death (  Dele 24 10 724 (14)  31. Date filed (Month, Day, Year) 32. Registrar's Si	He (6	fexent 1	en-	Colum	Sig M	7 21044	
	D:	Regist	rair .	DEC 0 6 2005 Frank #		es <sup>de</sup>	127 (12)				

DHMH 17 Rev 1/2001

			1 - For State of Maryland / Department of Registrar Cere	artment of Health and Natificate of Death	_	ene 0 0 5	39252			
			1. Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death			
	Physici		Anna Brock Carte	r	November	21, 2005	8:40a M			
<	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat				
17			Mariner Health Care	Glen Burnie		Anne_Ar	undol			
C	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth June 23	9. Birth	place (State or Foreign			
12 R	Director		214-50-4301 1□ M 2및F 88 Yrs.	Months Days Hours Min.	June" 23	, 1917 Mar	yland			
1	D .		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	4:						
$\cup$	the Marylan 28a-f show notified at	5					10d. Inside City Limits 1 ☐ Yes 2 ♣ No			
	the Mi	ectc	Maryland Anne Arundel Glen Bur							
4	11215-0036 within 72 hours after deeth with the Maryland ene. then "natural", or items 23e or 28a-f show the Medical Examiner must be notified at	Completed by Funeral Director	10e. Street and Number 1133 McHenry Drive	10f. Zip Code 21061	10	g. Citizen of What Co USA	untry?			
3	1036 burs after deeth with ral', or items 23e or Examinat must be.	era	·	Vas Decedent of Hispanic Origin? (Sp	acifu Vac or No-	14. Race - Ame	riogn Indian			
S. S.	after dee or items	Ş	Amed Forces?  1 Never Married 2 Married 1 Yes 24 No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	, etc.			
77	Urs al	by	3 Widowed 4 □ Divorced	Yes 2 No Specify:		Specify: W	nite			
1	15-0036	ted	15. Decedent's Education 16a. Decedentia	ent's Usual Occupation	. 1	6b. Kind of Business/	ndustry			
	21215-0 1 within 72 ho piene. r then "natur	ple	Elementaty/Secondary (U-12)   College (1-4or 5+)	kind of work done during most of work OO NOT use retired)	king					
	CA B P P	Son	8 Hor	nemaker		Own Hom	e			
	be filed that Hyg of othe	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, M	laiden Sumame)				
	aryland 212: 2 should be filed within and Mental Hygiene. 8 marked other then sumatic event, the Ma	2	Conrad L. Foerste			V	Arnold			
	re, Maryland 1 and 2 should be file 1 health and Mental H; tem 27 is marked oth other treumatic event	/ X		g Address (Street and Number or Rui			ip Code)			
	ed dea		Charlotte L. Chambers (Niece) 1133	McHenry Dr., Gle						
	Pages Pent of Hont: If Ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	natory or other place)		Oc. Location - City or				
	Baltimore, service, service, Pages 1 as Department of Hea mportent: If Item any injury or othe size.		4 Elbonation 3 Elother (Specify)			Baltimore,				
	Baltimor permit. Pages Department of H Importent: If Its any injury or of once.					rk Funeral				
			23a. Part: Chief the disease, or complications that caused the death. Do not ent	620 Wilkens Ave.,			Approximate			
			shock, or heart failure. List only one cause on each line.		or respiratory arre	si,	Interval Between Onset and Death			
	Physician /Medical		disease or condition resulting in death)	M						
	Examiner		Due to (or as a consequence of):	FAILURE						
		jer								
	18760, cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	Y TRACT	INFE	CTION				
	O, s exect an ar arial-t	EX	resulting in death) Last Due to (or as a consequence of):	1						
	68760, ifficate be ex g physician as the burial	dlcal	(d. ALZ6H1	MER'S D	EMEN	ITIA				
			IF FEMALE:							
	Box eath cert attendin for use	an/	23b Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnancy		23d. Date of deli				
	oe de the a	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		MOUTH	Day Year			
	P.O. hat the do by the detached		Part II. Other significant conditions contributing to death but not resulting in the ur	oderheine cause awen in Part I	23a Did tob	acco use contribute to	the equal of death?			
	ds, signe d be d	d by	Taken and a second seco	deriying dadse given in r dit i.	1 🗆 Yes		bably 4 Unknown			
	requipeen	Completed								
	Reclay he lay has ge 2 ;	mp			24a. Was an autopsy perform	prior to c	opsy findings available ompletion of cause of			
	n: Tr				1 Yes 2		<b>%</b> No			
	Vit sicle certi	Be C	25. Was case referred to medical examiner?  Hospital: Hospital:	Other	th (Check only one	-				
	Of Phy r this aral d	1: To	1  Yes 2 No	28c. Injury at Work?	28d. Describe how	nce 6 Other (Spec	ify)			
	ion Iding Ith. :: Afte e fune	to	1 X Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		, , ,				
	Division of Vital Records, to attending Physicien: The law requires taller death.  Director: After this certificate has been signed in by the funeral director, page 2 should be considered.	ifice	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre	et and Number or Ru	ral Route Number,			
	S affe	Certification:	building, etc. (Specily)		City or Town,	State)				
	lospii hour uner uner	edical	29a. Certifier (Check only control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the basis of examination and/or incomplete the control of the co	occurred at the time, date and place,	and due to the car	use(s) and manner as	stated.			
	Division of Vital Records, P.O. Box 6  To the Hospitel or Attending Physicien: The law requires that the death certifi within 24 hours after the certificate has been signed by the attending To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medi	and manner stated.							
	To To	-	29b. Signature and title of certifier	29c. License number		d. Date signed (Month	nd			
	in		My Miller MID	D 51596		OVEMBER	22 2005			
	(()		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	01	. D	MARIAL			
	Sta	ato	K. AMBALAVANAR 7845 Oc 31. Date filed (Month, Day, Year) 32. Register's Signature	Print) ylawood Road	, wiev	Durnie	ושטוגעוויו			
	Regist		DEC 0 6 2005 > Lange A	Jases						

_			1 - For State of M	laryland /	_	artment of He	ealth and Mental	Hygien Reg. N	UUU	39253
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Ronald Avon Coleman					mber	1, 2005	3. Time of Death
	Examin Funeral	er	4a. Facility Name (If not institution, give street and number,  Makyland Central  5. Social Security Number  6. Sex  7. Additional Control of the control of	Jospito	dl birthday)	4b. City, Town, or I Backin If Under 1 Year	URE CITY	of Birth	c. County of Death n/a 9. Birth	n nplace (State or Foreign
	Director		5. Social Security Number 6. Sex 11 M 2 □ F 7. At 212-56-9220 Usual Residence of Decedent	55	Yrs.	Months Days	Hours Min. June	27, Year	950 Mary	Tand
_	Maryland f show	ō	10a. State 10b. County MD n/a	10c. City, To						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
10/EIMU1	with the I	Direct	10e. Street and Number 3426 West North Ave.			10f. Zip Code 212	16	10g. C	itizen of What Cou	
EM.	tams 23	uneral	11. Marital Status 12. Was Decedent Armed Forces	?	13.		spanic Origin? (Specify Yes on, Mexican, Puerto Rican, etc.)	or No-	14. Race - Amer Black, White	
(%)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Exact are must be notified at once.	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:			I□Yes 2□No	Specify: Black			lack
	thin 72 h e. an "natu Medice	npiete	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	5+)	(Give life. I		uring most of working		Kind of Business/Ir	ndustry
(C) nd 2121	e filed wi Il Hygien other th	Be Con	17. Father's Name (First, Middle, Last)	D	enta	1 Technic	18. Mother's Name (First, M.	ddle, Maide	ntal Lab n Sumame)	
Prill Maryland	should by the Menta marked imatic events	<b>To E</b>	Lance Ruffin  19a. Informant's Name/Relationship (Type, Print)	15	9b. Mailir	g Address (Street ar	Gladys Colen		or Town State Zi	in Code)
	1 and 2 stealth ar tealth ar ther trau		Gladys Coleman - Mother  20a. Method of Disposition	3	426	West Nort	h Ave. Baltim	ore,	Maryland	21216
Baltimore,	Pages ment of h ant: if its ury or o'		1 🖾 Burial 2 □ Cremation 3 □ Removal from State  `4 □ Donation 5 □ Other (Specify)	Loudo	n Pa		ry Dec.5,05		location - City or T 1timore (	
Balt	permit. Depart Import any inj		21. Signatu Funeral Service Leensee	u	10	Name and Address 620 Wilke	of Facility Loudon ns AVe. Balti		Funeral H Marvland	
•	Physician /Medical Examiner		resulting in death)  Due to (or as	UM C s a consequence YCROS	o not ent  O(O)  e of):  C/t	er the mode of dying,		ory arrest,		Approximate Interval Between Onset and Death
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events c.	s a consequence						
P.O. Box 6	wrequires that the death certifics been signed by the attending pt should be detached for use as t	Physician/Medical		e of pregnancy 2  Fetal deat at time of death		Ectopic pregnancy Other (specify)			23d. Date of deliv Month	rery Day Year
	equires that en signed t	by	Part II. Other significant conditions contributing to death I	but not resulting	in the ur	ICERS			use contribute to t	the cause of death? bably 4 🖫 nknown
II Reco		Completed						Was an utopsy performed?	death?	opsy findings available ompletion of cause of
Division of Vital Records,	hys this al di	To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 npati 27. Manner of Death 1 Datatural 5 Pending (Month, Death investigation)		Outpatien . Time of Injury	t 3□ DOA Other 28c. Injury a Work?	4 Nursing Home 5	Residence	6  ☐ Other (Specially occurred	(y)
Divis	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, e	njury - At home, ' tc. (Specify)	farm, str	eet, factory, office	28f. Locati City o	on (Street a Town, Stat	nd Number or Run e)	al Route Number,
	he Hosp in 24 hou he Funei pletely fil	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st	of examination a	ge, death and/or inv	occurred at the time restigation, in my opin	e, date and place, and due to nion, death occurred at the t	the cause(s me, date an	s) and manner as s d place, and due t	itated. o the cause(s)
	To t with	Σ	29b. Signature and title of certifier Slaffill	- M	· D .	29c. License	9500	29d. Da	ate signed (Month,	Day, Year)
1			30. Name and address of person who completed cause of Mile Sharifle M	death (Item 23a	i) (Type,	Maryla	end Grener	al	Hospita	al
	Sta Registr		31. Date filed (Month, Day, Year) 32. Regist	trar's Signature	ha	housts &			/	
DH		001	DEC 0 6 2005	WALL BOY	25 5 m	19		•		

ORIGINAL

		-	1- State of Mai		artment of He		al Hygiene Reg. No.	05 39254
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Co	RDIS	, i	ate of Death onth Day CCMBER	3. Time of Death
	Examin Funeral	-		HOME (In yrs. last birthday)		LLE	BAL	INTY of Death IMORE  9. Birthplace (State or Foreign
L	Director		213-10-5050 1□M 2XF Usual Residence of Decedent	90 Yrs.	Months Days	Hours Min. 01	nte of Birth 701/1915	Couintry) MD
	e Marylar Ba-f show	Director	MD BALTIMORE	BALTIMORI				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s 23a or 2		8909 REISTERSTOWN ROAD		10f. Zip Code 21208			of What Country?
920	within 72 hours after death with the Maryland ene. Than "natural", or frams 23a or 28a-f show he Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Evarried Armed Forces 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	o		panic Origin? (Specify Yomesican, Puerto Rican, Specify:		Race - American Indian, Black, White, etc. ecity: WHITE
21215-0036	be filed within 72 ho ttal Hygiene. d othar than "natur evant, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Give	edent's Usual Occupati e kind of work done du DO NOT use retired) AKER	on ring most of working		of Business/Industry HOME
Maryland 2		To Be C	17. Father's Name (First, Middle, Last)  JULIUS	MACHLIN	1	8. Mother's Name (First	, Middle, Maiden Sun	mame) WINER
	and 2 salth ar n 27 ls er trau		19a. Informant's Name/Relationship (Type, Print)  ROSALIND CORDISH/DAUGHTER	400	KILREE ROA	<b>201</b> 1 <sup>ber or Rural Rout D – TIMONIU</sup>	M, MD 2109	93
Baltimore,	permit. Pages 1 a Department of Hes Important: If Itam any Injury or othe		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	BETH TFII	matory or other place) LOH	12/04/20	05 WOODLA	
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee		900 REISTE	of Facility SOL LE RSTOWN ROAD	- PIKESVI	ILLE, MD 21208
A	Physician		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition esulting in death)	the death. Do not enter.	ter the mode of dying,		iratory arrest,	Approximate Interval Between Onset and Death
	Medical Examiner  bhysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate  Cause (Disease or injury that initiated events  Due to (or as a Due to (or as a Cause) (Disease or injury that initiated events	consequence of):  consequence of):  consequence of):				
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 (11 ves, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d.	Date of delivery Month Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cause given	in Part I. 23	3e. Did tobacco use c	contribute to the cause of death?
Il Records,		Completed					4a. Was an autopsy performed  ☐ Yes 2 ☑ No	4b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
on of Vital	ding Physician: n. After this certific funeral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital: 1 Inpatient  27. Manne of Death 1 Natural 5 Pending (Month, Day)  2 Accident investigation	28b. Time o	of 28c. Injury a Work?	t 28d. D	777	Other (Specify)
Division	at or Attending s after death. I Director: After d in by the fune	Certification:	3 □ Suicide 6 □ Could not be	ry - At home, farm, st (Specify)		28f. Lo	ocation (Street and Nuity or Town, State)	umber or Rural Route Number,
	To the Hospital or At within 24 hours after d To the Funaral Direct completely filled in by	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medicel Exeminer: On the basis of e and manner state	examination and/or in	th occurred at the time nvestigation, in my opin	, date and place, and du nion, death occurred at the	e to the cause(s) and he time, date and place	manner as stated. ce, and due to the cause(s)
)	Tot Com	2	29b. Signature and title of certifier	$\mathcal{D}$	29c. License r	5000	300	nhe 2,2005
	1,7		30. Name and address of person who completed cause of dea		Print)	heet	21136	
	Sta Registi		31. Date filed (Month, Day, Year)  32. Pegistrar  DEC 0 6 2005	r's Signature	nain s			

			1 → For Stete Registrar	State of Maryland		artment of H			giene Reg. kg. 005	39255
	Physici	_	1. Decedent's Name (First, Middle, Las Donald A. Derby	,				2. Date of Dea Month	Day Ye	
	/Medio Examir	- 0	4a. Facility Name (If not institution, give  ST. AGNES			4b. City, Town, or Ba	Location of Dea		4c. County of [	00 12711
g:	Funeral Director		5. Social Security Number 6. Security Number 104-34-4544  Usual Residence of Decedent	7. Age (In yrs. Ia 7. Age (In yrs. Ia 7. Age (In yrs. Ia	Yrs.	If Under 1 Year Months Days	If Under 24 Hours Min		v. Year)	Birthplace (State or Foreign Country) ew YOrk
	ryland		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	the Ma	Director	MD Baltime	re	Cato	nsville			40 - 000	1 Yes 2 No
	3a or	i Dir	138 Cherrydell I	Road		10f. Zip Code	1228		10g. Citizen of Wha	,
	ams 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. V	Was Decedent of Hi f Yes, specify Cubai	spanic Origin?	(Specify Yes or No-	14. Race - A	American Indian, Vhite, etc.
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-1 show Ira Medical Evarritat must be redified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 🗖 No If Yes, Give Year or Dates:		I□Yes 2∏ No	Specify:	,	Specify:	
215-	hin 72 t a. In "nati Medica	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	cation de completed)  College (1-4or 5+)	(Give	lent's Usual Occupa kind of work done d OO NOT use retired,	furing most of w	rorking	16b. Kind of Busin	ess/Industry
21	filed wit Hygiene other tha		8	0		waiter			restaura	nts
anc	ould be fi Mental H arked ot atic ever	To Be	17. Father's Name (First, Middle, Last)  Lucius Albert	Perhy				ame <i>(First, Middl</i> e, ed Nichols		
ary	2 should and Men is marks sumatic	-	19a. Informant's Name/Relationship (7		19b. Mailin	g Address (Street a			or, City or Town, Sta	te, Zip Code)
altimore, M	ss 1 and of Health itam 27 other tr		Michael Derby/son  20a. Method of Disposition  1 □ Buriat 2 □ Cremation 3 □  4 ☆ Donation 5 □ Other (Specify	Removal from State	ace of Dispo	Genesis C sition (Name of natory or other place		2 Black M	Ountain, 20c. Location - City	NC 28711 or Town, State
Balt	permit. Page Department of Important: if eny injury or 2002.		21. Sunature Funeral Service Licent Ronald S.	Wade, Director	St	Name and Addres ate Anato Itimore,	omy Bóar		Baltimor	e Street
8760,	Physician and /Medical Examiner prize priz	dicai Examiner	shock or heart failure. List only of disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Atherose  Due to (or as a consequence.  Due to (or as a consequence.  Due to (or as a consequence.	ence of):	ofie (	Courdi	O VAJCO	clar Pis	Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the ettending physician and bage 2 should be detached for use as the burtal-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? t □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions of	entributing to death but not result	iting in the w	derlying cause give	on in Part I.	23e. Did to	,	Probably 4 Unknown
360	e taw re has bee ge 2 sho	Completed						24a. Was autop	sy prior	autopsy findings available to completion of cause of
taľ	ildian: Th conflicate rector, pag		25. Was case referred to medical				00 Black of D		200 1 🗆	Yes 2□ No
Ξ	Physicia this cert al direct	To Be	examiner?	Hospital: 1 ☐ Inpatient 2 €E	R/Outpatien	t 3 DOA Othe		eath (Check only of Home 5 Resid	lence 6 Other (	Specify)
ouo	Attending Physician: or death. ector: After this cartifice by the funeral director, p		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at t? Yes 2 □ No	28d. Describe h	ow injury occurred	
Division of Vital Records,	of or Attendated after death Director:	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	me, farm, stre			28f. Location (S City or Tow		r Rural Route Number.
	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funeral Director: Attenthis curificate his completely filled in by the funeral director, page	edicai C	29a. Certifier 1 Certifying Phyone 2 Medical Exam	vsicien: To the best of my know iner: On the basis of examinati and manner stated.	vledge, death on and/or inv	occurred at the time vestigation, in my op	e, date and place pinion, death occ	ce, and due to the courred at the time, of	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	To the To the Complet	Me	29b. Signature and title of certifier	1/200		29c. License	number 027	315	29d. Date signed (M	Ionth, Day, Year)
1	(0)		30. Name and address of person who	ompleted cause of death (Item	23a) (Type,	Print)	1		June	~ 30, 2005 6/4/more
7	Ste	ate_	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	MO ure	JO. 1	dyne;	Hosp:	tal 15	old more
	Regist		DEC 0 6 200	15 Marie 18.	1500		•			

			1 = For State Registrar	State of Maryland	/ Department of I Certificate of		ntal Hygien	2000	39256
	Physicia /Medio Examin	al	1. Decedant's Name (First, Middle, I KOMAN  4a. Fecility Name (If not institution, g Saint Joseph	- DUDEK	4b. City, Town,		CEMBER	Day Year  1.2005  Ic. County of Deal  Balt	
-	Funeral Director		5. Social Security Number  213-20-7034  Usual Residence of Decedent	Sex 7. Age (In yrs. la	(Ast birthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea 5 / 11 / 192	9. Birt	thplace (State or Foreign buntry) RRY AND
	72 hours after death with the Maryland natural; or Items 23a or 28e-1 show disal Examiner must be notified at	ector	10a. State 10b. County  BALT	10c. City,	RALTIMOR	E	10- 6	200	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	death with t ms 23a or 2	Funeral Director	10e. Street and Number 9405 Fuller 11. Marital Status	2 DALE AVE.	10f. Zip Code  21  6. 13. Was Decedent of	234 Hispanic Origin? (Specifican, Mexican, Puerto Ric		USA  14. Race - Ame	erican Indian,
9000	hours after ural', or ite	by	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No	Specify:		Specify:	HITE
21215-0036	within ene. than	Completed	15. Decedent's (Specify only highest (Specify only highest (12))		16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire MUSICLAW	during most of working ad)	E	Kind of Business	·
Maryland	hould be filed id Mental Hygi marked other matic event, I	To Be	17. Father's Name (First, Middle, La  JOSEPH  19a. Informant's Name/Relationship	DUDEK	19b. Mailing Address (Stree	18. Mother's Name (P	IE PE	TRIZK	SOWSKA
	Pages 1 and 2 sho nent of Health and ant: if Item 27 is m ury or other traum		MIDRED D. Box 20a. Method of Disposition 1 Deurial 2 Cremation 3		ace of Disposition (Name of metery, crematory or other pla	RADOR LA Date  DECEN	BER 200.	EKEYSUI Location - City or	Town, State
Baltimore,	permit. Pages Department of Important: If I any injury or once.		4 Donation 5 Other (Spe 21. Signature of Buneral Service Lie	ensee	MEMORIAL GAR 22. Name and Addr 8800 HAI			monium erac Ca ville m	IAPEL
10	Physician /Medical Examiner	_	23a. Part! Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	PERFORATED I Due to (or as a consequence) SEPTICEMIA	BOWEL ence of):	ing, such as cardiac or n	espiratory arrest,		Approximate Interval Between Onset and Death
8760,	ate be executed thysicien and the burial-transit	dical Examiner	Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	SHOCK  Due to (or as a consequence)					
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy age 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal of 4 □ Pregnant at time of dea 9 □ Unknown	death 3 Ectopic pregnand	гу		23d. Date of de Month	iivery Day Year
<u>α</u>	w requires that been signed b should be deta	by	Part II. Other significant condition	3 contributing to death but not resul	lting in the underlying cause g	iven in Part I.		4	o the cause of death? robably 4 DUnknown
al Records,		Completed					24a. Was an autopsy performed? 1 Yes 220 N	prior to	utopsy findings available completion of cause of
of Vital	Physici r this cer ral direc	To Be	25. Was case referred to medical examiner?  1  Yes  2 No  27. Manner of Death	28a. Date of Injury	28b. Time of 28c. Inju	26. Place of Death (ther: 4 Nursing Home ury at 280			city)
Division	Hospital or Attending P 24 hours efter death. Funeral Diractor: Alter i itely filled in by the funera	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 4 Homicide determin	t be One Disco of Injury At hos	M 1 [	]Yes 2□No	. Location (Street a City or Town, Sta		ural Route Number,
	To the Hospital or Atte within 24 hours efter de To the Funeral Directo completely filled in by the	Medical C	29a. Certifier  (Check only one)  2 Medical Expone)	Physician: To the best of my know kaminer: On the basis of examinati and manner stated.	wledge, death occurred at the lion and/or investigation, in my	time, date and place, and opinion, death occurred	due to the cause at the time, date a	(s) and manner as nd place, and due	s stated. e to the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	100	29c. Licen D 225	ise number	29d. D	Date signed (Mont	h, Day, Year)
	0+/	-	ASSAN MAKHZOUM		SLER DRIVE	TOWSON MA	RYLAND	21204	
6	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 6	2005 32. Adgistrar's Signati	f. Agardis			•	

2/23/06 KRH Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 3 per Dr. g852 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death OU: 11Peath Day Month Year **Physician** 30, 5002 september /Medical acility Name of not institution, give street and number) 4c. County of Death Location of Death **Examiner** Josex 6. Sex Funder 1 Year | If Under 24 Hrs. Lospital Johns 8. Date of Birth (Month, Day, Year) Funeral 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours 13 Days Min. Months 1□M 2√F Yrs. Director 33 Maryland Sept 30, 2005 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic evant, the Medical Examiner must be notified at 1√Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21224 or Itams 23c 416 N. Linwood Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give ★ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No þ Specify: black 3 Widowed 4 Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ges 1 and 2 should be filed within tof Health and Mental Hygiene. If Itam 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) none none 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Be Shante Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) The Johns Hopkins Hospital 600 N. Wolfe Street Baltimore, MD 21287 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or '4 □Donation 5 ♥ Other (Specify) in state 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 Rouald Sa 655 W. Baltimore Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** e /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of): attending physician Box 68760 ician/Medical as the t IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the ģ been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 KN0 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has 1 Yes 2 Nb Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Impatient 2 EP/Outpatient 3 DOA ပ 1 🗌 Yes this 27. Manner of D 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attanding Physician: Diractor: within 24 hours a

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. 29b. Signatu title of certific

29c. License number

29d. Date signed (Month, Day, Year)

25-000

2005

30. Name and address of person cause of death (Item 23a) (Type, Print) Simo

102

600 N Wolfe St Baltimore

State Registrar

29a. Certifier

DEC 0 6 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral 39258 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month 2005 November 2:50 A John Gabriel DeMinds /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F 48 219-62-5273 Yrs **Director** Dec.7,1956 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show r then "nature), or items 23s or 28s-f show the Wedical Examiner must be notified at 1 Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21223 USA 476 S. Bentalou Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □XYes 2 □ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed <u>12th grade</u> Caterer ie marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be i James Cornish Mary Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4224 Crawford Ave Baltimore, Maryland 21215 Pages 1 and 2 ment of Health a lant: if item 27 is Rose M. Pugh/ Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 5 1 Kurial 2 Cremation 3 Removal from State 12-2-05 permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veteran Com. Crownsville, Md 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licens 5240 Reisterstown Rd Baltimore, Md 21215 MINNS 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gunshot Wolund /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). certificate be executed burial-transit and Due to (or as a consequence of) Box 68760, attending physicien for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 50 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificete has L lirector, page 2 s autopsy performed? death? 1√2 Yes 2 □ No 2 No 1 X Yes of Vital : After this certifical tuneral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To Yes 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural i efter death. I Director: Af d in by the fur buck 5401 1 ☐ Yes 2 ☑ No :25 2 Accident 65 3 ☐ Suicide 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter de To the Funeral Directo completely filled in by ti Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital or S VER7 2400 Frederick Ave Baltimore, My 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 2, 2005 death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, 32. Resistrar's Signature State Registrar DEC 0 6 2005

			1 - For State Registrar		State o	f Marylar		artment of H			giene	5 3925	9
	Physic		1. Decedent's Name ( Enid		E.		Dudle	ev		2. Date of De Month	eath Day	Year	Death A_M
	/Medi Examir		4a. Facility Name (If no Union M		ve street and nu	·		4b. City, Town, or	Location of Death	Merent		y of Death	10
I	Funeral Director		5. Social Security Num 110-12-44	6. 38	Sex 1 □ M 2√□ F	7. Age (In yrs. 95	/ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th 179ar) 15-10	9. Birthplace (State or Country) West Inde	
	eryland ahow	_		0b. County		10c. Cit	ty, Town or Lo	cation	· · · · · · · · · · · · · · · · · · ·			10d. Inside City	•
	ith the M or 28a-f	Funeral Director	Md.  10e. Street and Numb	NA er			Balt	imore 10f. Zip Code			10g. Citizen of	1 ☑ Yes What Country?	2   No
	23.	<u>e</u>	517 E. 2	3rd Str	eet			212	18		USA	1	
215-0036	is 1 and 2 should be filed within 72 hours after deeth with the Meryland of Heelth and Mentei Hyglene. Itsm 27 is marked other than "natural", or itema 23s or 28s-f show other traumatic event, it a Medical Exerciter must be notified at	Þ	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4	_	12. Was Dece Armed Fo 1 ☐ Yes If Yes, Giv Year or D	ATXNo		Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	- 14. Ra Bla Specif	ce - American Indian, ck, White, etc.	
9	72 ho	ted	(Specific	5. Decedent's E	ducation		16a. Deced	ent's Usual Occupa	ation		16b. Kind of B	dusiness/Industry	
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Ē	be til d ott	Be	17. Father's Name (Fil	rst, Middle, Las	")				18. Mother's Name	e (First, Middle,	Maiden Sumar	me)	
Maryland	should and Men amarka umatic	ဥ	Unkn 19a. Informant's Name	o/Poloticochin	Time Print)		105 Maille	- 144 (0)	Amy		anch	Trotman	
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	tand Heeith tam 27 other to		Brenda Di 20a. Method of Dispos		Daugh	20b. F	Place of Dispos	E. 23rd sition (Name of	Street,	Baltimo	re, Md.	21218 - City or Town, State	
Baltimore,	Pege nent c ant: If ary or		1 Burial 2 0	Other (Speci	(y)	State	King Me	m. Park	12-8	-05	Randal	lstown, Md.	
Ba	permit. Depertr Importe any inju		21. Signature of Fune	All	3		M	Name and Addres	. East	1101 E	imore, . North		
68760,	Physician /Medical Examiner  pue veicieus que le liceus que liceus que le liceus que le liceus que le liceus que le liceus que liceus que le liceus que le liceus que le liceus que le liceus que liceus que le liceus que liceus	dical Examiner	23a. Part1. Enter the shock, or heart it lisease or condition resulting in death)  Sequentially list condition from the shock of the sh	alure. List diffy nal tions, ediate ing ury	a. None cause on e	or as a conseq	uence of): NSION uence of):	INFarc				Approximate Interval Betwe Onset and De	een
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	sign d be	Ď	Part II. Other significa	nt conditions	contributing to de	ath but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Did to	V	ribute to the cause of dea 3 ☐ Probably 4 ☐Un	
Vital Records,		e Completed	25. Was case referred	to modical						24a. Was a autop perfor 1 Yes	med?	Were autopsy findings avorior to completion of caudeath?  Yes 2 No	ailable ise of
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ion of	Attending Phy deeth. ctor: After this y the funerel o		27. Manner of Death	5 ☐ Pending investigatio	28a. Date o (Monti	f Injury h, Day Year)	28b. Time of Injury	28c. Injury Work	4 □ Nursing Hor at ? es 2 □ No		ow injury occurr		
Division	To the Hospital or Attending within 24 hours effer deeth.  To the Funeral Director: Affer completely filled in by the fune	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not b determined	286. Place	of Injury - At ho	me, farm, stre	et, factory, office	2	28f. Location (S City or Tow	treet and Numb n, State)	er or Rural Route Numbe	ır,
	na Hospi n 24 hou na Funar netely fill	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Pt	ysician: To the niner: On the ba and mann	sis of examinat	wledge, death ion and/or inve	occurred at the time estigation, in my opi	e, date and place, a inion, death occurre	and due to the c	ause(s) and ma late and place, a	nner as stated. and due to the cause(s)	
<b>)</b>	To the within 2 To the complet	×	29b. Signature and title	of certifier	Kan			29c. License				i (Month, Day, Year)	
7	1	-	30. Name and address	of person who	completed cause	of death (Item	23a) (Type P	rint) Usi	53373	1 1000	recense	103,200	5
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8	Sta Registr		31. Date filed (Month;)	1	32. Re	gistrar's Signat	ure	esta de la companya della companya d	N INTON	- <del></del>	VICTO		
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		•	For State Registrar	State of Maryl		artment of H			ene 005	39261
	*	2	Decedent's Name (First, Middle,)	Last)				2. Date of Death	n	3. Time of Death
	Physicia /Medic		Etlow	Echols				Month 11 30	Day Yeer 2005	1:39 p. M
	Examin		4a. Facility Name (If not institution, g	give street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	th
- 4			401 E. 25th S	treet		Balti			N/A	
	Funeral		Social Security Number	1□M 250E	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12 26	Year) 9. Bir	thplace (State or Foreign ountry)
	Director		217-24-1200	75	Yrs.			12 26	1929	MD
	and **		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Manyl 1 •ho	5	MD		Baltim	ore				1 ¥ Yes 2 No
	the t	Director	10e. Street and Number		Darcin	10f. Zip Code		16	0g. Citizen of What C	ountry?
	3a or	Ö	401 E. 25th S	treet Ant 2B		2121	8		USA	
	me 2:	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	Was Decedent of H	ispanic Origin? (Spe	ecity Yes or No-	14. Race - Am	
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or iteme 23a or 28a-f ehow or other treumatic event, the Medical Examinatments be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		ir Yes, specify Cuba 1 ☐ Yes 2 🙀 No	Specify:	Hican, etc.)	Black, Whi	
Ö	hou sture		15. Decedent's		16a. Dece	dent's Usual Occup	ation		16b. Kind of Business	
21215-0036	n n	Completed	(Specify only highest Elementary/Secondary (0-12)		(Give	kind of work done of DO NOT use retired	during most of work d)	ing		
212	within piene. r then	E	7th	College (1-401 3+)	Bar	Maid			Bar	
	Hygid other	a)	17. Father's Name (First, Middle, La	ist)			18. Mother's Name	e (First, Middle, N	Maiden Sumame)	
lar	Mental arked o	To B	William	Burke			Mazie		John	son
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, me Mi	0.3	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health em 27 i		Edward Cooper-so				St. Apt.			21001
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3		Ob. Place of Dispo cemetery, crea	osition (Name of matory or other plac		Date	20c. Location - City o	Town, State
Ĕ	Pages nent of B ant: if its ury or o		4 Donation 5 Other (Spe		Mt. Zio	on Cemete	ry 12-	6-05	Lansdowne,	MD
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Li	censee Ware		2. Name and Addre	ss of Facility MAR orth Avenu		RAL HOME-E	AST 21202
140	=		23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused the	death. Do not en	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final	•	ssive 1	locat At	to b			Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a cor	nsequence of):	leuri m	Tack			
	Examiner			Dist	notes 1	+ weekens	teck	v1-pidem:	4	OVEY 20 leurs
1/		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a con	nsequence of):	,,				
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o,	an ar	Ä	resulting in death) Last	Due to (or as a con	nsequence of):					
8760,	ficate be executed physician and is the burial-transit	dicai		d						
9	artifica ing pl	0	IF FEMALE:							
Box	ath ce ttend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3	Ectopic pregnancy	,		23d. Date of de Month	Day Year
P.O. E	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	Completed by Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	of death 5	Other (specify) _				
	s that	آخ ا	Part II. Other significant condition	s contributing to death but no	t resulting in the u	inderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
P. C.	w requires that been signed be should be det	D D	Stroke	, parkinson	is dise	ase		1 ☐ Ye	os 2 <b>X</b> No 3□F	robably 4 Unknown
00	s bee	Siet		·				24a. Was a		utopsy findings available
Re	The la	E						autops perform	ned? death?	completion of cause of s 2 No
tal		BeC	25. Was case referred to medical				26. Place of Deat			
<u>&gt;</u>	Physician: r this certifica ral director, I	To B	examiner? 1 ☐ Yes 2xx No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie	nt 3 DOA Oth	ner: 4 Nursing Ho	me 5 Reside	ence 6 Other (Sp.	ecify)
0	ding Phys h. After this tuneral dir	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	of 28c. Injur Wor	y at	28d. Describe ho	w injury occurred	
10	Attending ir death. ector: After by the fune	atic	1 Natural 5 Pending 2 Accident investiga	ition	, ,,,,,		Yes 2□No			
Division of Vital Records,	ter de irecto	Certification:	3 Suicide 6 Could no 4 Homicide determin	of be 28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,
	ital curs af				-	<u> </u>				
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely filled in by the funeral director.	Medicai	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the best of my xaminer: On the basis of exa and manner stated.	y knowledge, deal imination and/or in	th occurred at the till expection, in my o	me, date and place, opinion, death occur	and due to the ca red at the time, da	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)
	To th	Me	29b. Signature and title of certifier			29c. Licens	,	2	9d. Date signed (Mor	
		1	Lan	NI INS	>	D	0056254		12/02/	2005
	1).		30. Name and address of person w	no completed cause of death	(Item 23a) (Type,	Print)				
	4		Dr Nan.	NI. Union h	nement	Hospital. 20	1 E. 33rd :	st. Buth	L, MD 21.	218
		ate	31. Date filed (Month, Day, Year)	VI, Union M 32. Agistrar's	Signature	Carl I				
100	Regist	rar	DEC 0 (	2005 Masure	15 14					

			For State Registrar	State of Ma	aryland / Depa	artment of F		-	200	5 39262
12	1 3	7	Decedent's Name (First, Middle, L.)	.ast)		invocato or	<b>D</b> 0 dt. 1	2. Date of De	Reg. No.	3. Time of Death
¥	Physici		Georg	е Н.	Elder, J	r.		Deen	be Bay & s	in 753 1M
	/Medic Examir		4a. Facility Name (If pot institution, g		/ / /	4b. City, Town, o	r Location of De		4c. County	of Death
1			Maryland 6	reneral x	Lospital	Baltin	nore	Crty	N/A	
	Funeral		5. Social Security Number 6.	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 H	n. 8. Date of Bir	th ay, Year)	9. Birthplace (State or Foreign Country)
47	Director		216-16-4628 Usual Residence of Decedent	IAIM ZLIF	88 Yrs.			Nov. 1	3, 1917	Pennsylvania
	land ow		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Mary	ţō	Maryland N/A		Baltimor	6				1 X Yes 2 □ No
	r 28a	lrec	10e. Street and Number		Baronnor	10f. Zip Code			10g. Citizen of V	Vhat Country?
	th witi	a D	1315 John Stre	et		21217	7		U.S	.A.
	eme err	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No	- 14. Race	e - American Indian, k, White, etc.
36	or It	by Fu	1 Never Married 2 Married	1 Yes 2 □ N If Yes, Give	10	1 □ Yes 2 □ <b>X</b> No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify	
21215-0036	72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f ehow ofical Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:		dent's Usual Occup	ti-a			White
5	in 72	Completed	(Specify only highest s	grade completed)	(Give	kind of work done DO NOT use retired	during most of w	vorking	16b. Kind of Bu	isiness/industry
212	d with	E	Elementary/Secondary (0-12)	College (1-4or 5		ineer			Fnain	eering
nd.	al Hyg	Be C	17. Father's Name (First, Middle, La	st)			18. Mother's N	ame (First, Middle		
<u>a</u>	Menti Menti arked	은	George El	der, Sr.			Anna	Macri	um	
Maryland	2 sho		19a. Informant's Name/Relationship	78.5	19b. Mailii	ng Address (Street	and Number or i	Rural Route Numb	er, City or Town,	State, Zip Code)
6, 1	permit. Pages 1 and 2 should be filed within 72 hours after deal Obspatiment of Heelih and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme any Injury or other treumatic event, the Maccal Examiner or once.		Barbara Elder 20a. Method of Disposition	Wife	20b. Place of Dispo	John Str	reet	Baltimore		
٥	ages or of h		1 ☐ Burial 2 🔀 Cremation 3		cemetery, crei	matory or other plac	*			City or Town, State
Baltimore,	iit. Piz kritmer prtent injury		4 □ Donation 5 □ Other (Special Control of Africa Service Lice	* -	Hilltop S				Towson	
Ba	Depa Impo any I		A A A A A A A	igan		2. Name and Addre 1050 Yor	rk Road	luck Tows Towson	on Funer , Maryla	al Home, Inc. nd 21204
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused by one cause on each lii	the death. Do not ent	ter the mode of dyir	such as cardi	iac or respiratory a	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	- COror	rary HR	HERY!	Disea.	se		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	n-1 .				
		er	Sequentially list conditions,	t. Huffl	a consequence of):		0 4		1	
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8760,	ficete be executed physicien and s the burial-transit	dicai		o. KlSpira	atory_	Losur	Freie	ency		
9	ng ph as th	Jedi	IC CCMALC.	, ,			-			
Вох	death certifi e attending id for use as	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth		Ectopic pregnancy	v			e of delivery
	thet the death certifi led by the attending of detached for use as	Physician/Me	1 Yes 2 No	4□Pregnant at 9□ Unknown	time of death 5	Other (specify)			Moi	nth Day Year
P.0	het th ed by detac	P.	Part II. Other significant conditions	s contributing to death b	ut not resulting in the u	nderhina cause an	ren in Part I	23a Did 1	obacco use contr	ibute to the cause of death?
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cor	w requir been si should I	iete						24a. Was	an 24h 1	More autopou findings available
Re	o c o	Completed						auto perfo	psy prmed?	Vere autopsy findings available prior to completion of cause of leath?
ta	ician: Th certificate rector, pag	Be	25. Was case referred to medical				26 Place of D	1 ☐ Yes eath (Check only o		Yes 2 No
<u> </u>	Physician: this certific ral director,	To B	exammer? 1 ✓ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpatier	nt 3 DOA Oth	nor.	Home 5 ☐ Resi		er (Specify)
			27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time o	f 28c. Injur Wor	ry at		how injury occurr	
sion	Attending r death. ector: After on the fune	catic	2 Accident investigat	ion			Yes 2 □No			
Division	or Att	Certification:	3 Suicide 6 Could not determine	28e. Place of Injusted	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location ( City or To	Street and Number wn, State)	er or Rural Route Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	2	29a. Certifier 1 Certifying	Physician: To the bear	of muckey-ulada = - d - :	h accured to the co	mo deta a tri			
	Hos 24 hc Fun etely	Medical	(Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	examination and/or in	vestigation, in my o	me, date and pla opinion, death oc	ce, and due to the curred at the time,	date and place, a	nner as stated. and due to the cause(s)
	To the within To the Complex c	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signed	(Month, Day, Year)
			100	Uhms	-1, has	8	9535	5	12,	13/05
	11		30. Name and address of berson wi	so completed cause of d	eath (Item 23a) (Type,	Print)	0,0000	0 1/200	1.0	
	2		A Of I Uwusu	M.U. 40	Mary	and bro	nekas	HOSP	wal	
	Sta Regist		31. Date filed (Month, Day, Year)		ar's Signature	100				
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DHMH 17 Rev 1/2001

		1 - For State Registrar	State of Maryland		artmen rtificate					Reg. No.	)5	39263
Physicia /Medic Examin	al	DOROTHY  W  4a. Facility Name (If not institution, give s	FLOYD		4b. City,	Town, or	Location of		2. Date of De Month	Day Day 4c. County		3. Time of Death  12:15 A
Funeral Director		FUTURE CARE OLD CO  5. Social Security Number 6. Sex 1		st birthday) Yrs.		DALL 1 Year Days	STOWN If Under 2 Hours	4 Hrs. Min.	8. Date of Bir (Month, Da	th ay, Ye <i>ar)</i>	175.0	lace (State or Foreigr try)
D	ector	Usual Residence of Decedent  10a. State 10b. County  MD BALTIMOR	10c. City,	Town or Lo	ALLST				07/17/			0d. Inside City Limits 1 XYes 2 □ No
ING 21215-UU36  be filed within 72 hours after death with the Marylan tall Hygiene. Ind other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be indiffied at	ted by Funeral Director	1 Never Married 2 Married 3 Novidowed 4 Divorced  15. Decedent's Educ	12. Was Decedent Ever in U.S Armed Forces? 1 Tyes 22 No If Yes, Give Year or Dates:	16a. Dece	If Yes, spec 1 ☐ Yes 2 dent's Usua	lent of His	Specify:	Puerto R			ce - Americ ick, White,	an Indian, atc. <b>CK</b>
Maryland 21215 to 2 should be filed within 7 th and Mental Hygiene. 27 Is marked other than "n traumatic event, the Med	To Be Completed	(Specify only highest grade Elementary/Secondary (0-12) 7 17. Father's Name (First, Middle, Last) ADGER WEST	College (1-4or 5+)	life.	kind of wor DO NOT us	e retired)		r's Name (	(First, Middle	HFA , Maiden Sumar		
Baltimore, Maryls permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 Is marke any Injury or other traumatic		19a. Informant's Name/Relationship (Type DION EUGENE FLOYD)  20a. Method of Disposition  1 Relation 1 Cremation 3 Relationship (Specify)  21. Signature of Funeral Service License	/SON  20b. Pla cer ARL	413 ice of Disponentery, cres	osition (Nammatory or of Nata	wn Bane of their place. CEI d Address	ARK C  M 12 s of Facility	IRCLI Da  /12/2	Route Numb  E, RAN  tte  2005  ES A. 1	DALLSTON  20c. Location  ARLINGTOM  MORTON &  TIMORE,	ON, VA	21133 wn, State
Physician /Medical Examiner  physicien and physicien and the prital-transit	ical Examiner	23a. Part. Enter the disease, or complic shock, or heart lailure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to vor as a conseque	ence of):			rod ex		respiratory a			Approximate Interval Between Onset and Death
death certificate attending pto defor use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregnan- 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	death 3	□Ectopic pre						ate ot delive	ry Day Year
The law requires that the set has been signed by the page 2 should be detached.	Completed by PI	Part II. Other significant conditions con  HTN CUM  Cevere TMA	tributing to death but not result						1 🗆 1	Yes 2□No an 24b. psy prmed?	3 Proba	e cause of death?  abiy 4 Denknown  asy findings available appletion of cause of
on of Vitaling Physician:  After this certific funeral director.	Certification; To Be C	25. Was case referred to medical examiner?  1  Yes 2  No  27. Manner of Death 1  Natural 5  Pending investigation 3  Suicide 6  Could not be determined	ospital:  1	28b. Time o Injury	M 28	Bc. Injury Work 1 🗆 Y	r: 4 🗆 Nur	sing Home	d. Describe	dence 6 Oth	red	)
To the Hospital or Attent within 24 hours after death within 24 hours after death or the Funeral Director:  completely filled in by the	Medical Co	29a. Certifier (Clock only) 2   Medical Examin  29b. Signature and title of certifier	ician: To the best of my knowner. On the basts of examination and manner stated.	ledge, deat on andvor in	vestigation,	in my op	number	n occurred	at the time,	cause(s) and madate and place,	and due to	the cause(s)
Sta Registr		30. Name and address of person who con よれみれいかが シュウショの 3  31. Date filed (Month, Day, Year)	mpleted cause of death (Item a completed Cause of death (Item a c	- (E)	Print)	ROA	2 4	y Fi	ESVIL	LE M	D 21	784

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 29, 2005 ANNA MAE WINEBRENNER FEIGH November 11:30/Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Heart Homes Lutherville Funder 24 Hrs. 8. Date of Birth (Month, Day, Year)
Aug 13, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1□M 21 F 1916 89 Maryland Director 212**-1**4-6848 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State rai', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director Baltimore City N/AMaryland | 10g. Citizen of What Country? 10e. Street and Number 21212 Funeral 310 Evesham Avenue death 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Itam 27 ie marked other than "natural; or Iter any injury or other traumatic event, The Mudical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 XWidowed 4 ☐ Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Coflege (1-4or 5+) Elementary/Secondary (0-12) Hair Care Beautician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dudderar Elsie Marshall Winebrenner 7 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) 310 Evesham Avenue, Baltimore, Maryland 21212 of Disposition (Name of Date 2.c. Location - City or Town, State Parbara F. Capak (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ₽Buriaf 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Dec 3, 2005 Parkville, Maryland Parkwood Cemetery 21. Signatured Funeral Service (Iconsess

Martin D. Lawson

Martin D. Complications that caus 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Maryland 21212, Approximate the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Mysoudeal Manute Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner burial-transit Due to (or as a consequence of) P.O. Box 68760 Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Division of Vital Records. Ď 1 Yes 2 No 3 Probably 4 Unknown alroner Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an leven certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes ZNo 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Dath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital o within 24 hours af To the Funeral D To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number erlein MI 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 411 Donald Weglein, M.D. GBMC West Pavillion, Towson, Maryland 21204 State DEC 0 6 2005 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 15 Figure 124ac #24ac Per PHY G850 PS/06705 9HDeath Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 15, 2005 November 9:08 PM George Grenier /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Joseph Richey Hospice Baltimore If Under 1 Year Months Days If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1**√**M 2□ F Yrs Director 138-22-1737 July 18, 1928 New\_Jersey Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2√☐ No Director Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 1201 Hilton Avenue USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 146-49 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced natural Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) chef other food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental F permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked cany jury or other traumatic eve 9068. Anthony Joseph Grenier Jenny L. Singer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Grenier/spouse 1201 Hilton Avenue Catonsville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ∑Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Ronald S. Made 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 mar 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate cause (Final disease or condition resulting in death) hoonic Physician Uremia 4 CLY /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inifiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an performed? 1 ☐ Yes XX No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSPICE Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No 2 this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24321 unt 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eutan St Battomine MD 821 hilip 31. Date filed (Month) Day, Year) 32. Registrar's Signature, State 6 Registrar

			1 - State of Maryland / Department of Health Certificate of Death		al Hygier Reg. 1	4000	39266
	Physici /Medic		1. Decedent's Name (First, Middle, Last) PELORES GLASCOE	2. Da	te of Death onth	Day ZOOF	3. Time of Death S. 45 P M
	Examir		HOWARD COUNTY GENERAL COLUMBIA			4c. County of Dea	hth  Thplace (State or Foreign
	Funeral Director		213 · 30 · 5455  Usual Residence of Decedent	Min. (M	onth, Day, Ye. 17-193	ar) C	ountry) MD
	death with the Maryland ims 23a or 28a-1 show	ctor	10a. State 10b. County 10c. City, Town or Location COLUMBIA				10d. Inside City Limits 1 ☐ Yes 2 🗷 No
	ath with th	rai Director	10e. Street and Number  10f. Zip Code  21045		10g.	Citizen of What C	•
336	hours after des lurei', or items	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Zidivorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, 2 No If Yes, Give Year or Dates:  11. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica	an, Puerto Rican,	es or No- etc.)	14. Race - Am Black, Whi	
Maryland 21215-0036	ne ne	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during mo	ost of working		. Kind of Business	/Industry
and 2	should be filed within a Mental Hygiene. marked other than matic event, II a M.	Be	17. Father's Name (First, Middle, Last)  18. Moth	her's Name (First		EALTH C	AKE.
	and 2 should be i ealth and Mental I n 27 is marked of ier treumatic eve	Δ	19a. Informant's Name/Relationship (Type, Print)  NAJALA S. WARD (DAUGHTER)  19b. Mailing Address (Street and Numb 19b. Mailing Address (Street and Numb 19b. Mailing Address (Street and Numb	ber or Rural Rout	e Number, Cit	ty or Town, State,	
Baltimore,	Pages 1 nent of H ant: If iter ary or oth		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 11 · 30 · 05	20c.	Location - City or	
Balt	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee  22. Name and Address of Facility VAUGHN C. GREENE 5151 BATO. NATL PI			and the second second	
	Physician /Medical Examiner		23a. Part1. Ent The disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	as cardiac or respi	iratory arrest,		Approximate Interval Between Onset and Death
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09/80	licate be executed physician and s the burial-transit	edical E		E			
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rds, P.	w requires that been signed by should be deta			t I. 23	3e. Did tobacc		o the cause of death?
II Kecords,		Completed			la. Was an autopsy performed	? prior to death?	utopsy findings available completion of cause of
r Vital	d is	To Be	examiner?	ce of Death (Check Nursing Home 5		6 □Other (Spe	ocify)
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Division	To the Hospitel or Attending F within 24 hours atter death. To the Funerel Director: After completely filled in by the funers	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		cation (Street ty or Town, Sta		ural Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical	29a. Certifier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date as 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date as 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date as 2 Medicel Examiner: On the basis of my knowledge, death occurred at the time, date as 2 Medicel Examiner: On the basis of my knowledge, death occurred at the time, date as 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date as 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date as 3 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date as 3 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date as 3 Medicel Examiner: On the basis of examiner and occurred at the time, date as 3 Medicel Examiner: On the basis of examiner and occurred at the time, date as 3 Medicel Examiner: On the basis of examiner and occurred at the time, date as 3 Medicel Examiner: On the basis of examiner and occurred at the time, date as 3 Medicel Examiner: On the basis of examiner and occurred at the time, date as 3 Medicel Examiner: On the basis of examiner and occurred at the time, date as 3 Medicel Examiner: On the basis of examiner and occurred at the time and occurred at the time at 3 Medicel Examiner: On the basis of examiner and occurred at the time.	eath occurred at th	ne time, date a	and place, and due	o to the cause(s)
1	S o o o	Z V	1 XXIIIS WD 25398	7	29d. [	Date signed (Mont	2005
	L		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENN ET SOO ALWOLY SUITE 3G BATTI MOR	a m	tt 11	201	
*	Sta Registr		DEC 0 6 2005				

		4	For State Registrar	State of Maryland / Dep.	artment of Health and rtificate of Death	Mental Hygie	7 11 10 39701
w.	· · · · · · · · · · · · · · · · · · ·		Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physici /Medic		JOHN P. GRAH	Am		A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A 100 A	Day Year 11 20 A M
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
100			ST AGNES HE	SPITAL	BALTIMO	RE	NA
	Funeral Director		5. Social Security Number 6. Sex 1 № 2153	M 2 F 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs   Months   Days   Hours   Min.		9. Birthplace (State or Foreign Country) SC
	pur *	} }	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Le	ncation		10d. Inside City Limits
	lanyla sho	ō	MD NA	BALTIMORI			1 X Yes 2 No
	28a-	ect	10e. Street and Number	DALITION	10f. Zip Code	10g	Citizen of What Country?
	With 3a or	0	4009 WOODRIDGE	ROAD	21229		USA
	itams 2	Funeral Director		2. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,
9	or its	T.	1 Never Married 2 Married	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give	If Yes, specify Cuban, Mexican, Puer  1 Yes 2 No Specify:	to Hican, etc.)	Black, White, etc.
93	72 hours after death with the Maryland 'natural', or Itams 23e or 28e-1 show digal Exercities must be rediffed at	d by	3 Widowed 4 Divorced	Year or Dates:	TILL Tes 282 No Specify.		Specify: BLACK
215-0036	72 h nætu	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of wo	rking 16b	. Kind of Business/Industry
121	within ene. then "	d L	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)  BOREL	141	arehouse
d 21	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "naturel", or items 23e or 28e-1 show event, Ita Medical Evan fran med be notified at		10 1H GRADE  17. Father's Name (First, Middle, Last)	NA		me (First, Middle, Maid	
Maryland		To Be	MILES GRAHAM		FANNIE	SMITH	
ary	shou and N	-	19a. Informant's Name/Relationship (Typ	pe, Print) 19b. Maili	ng Address (Street and Number or Ri		ty or Town, State, Zip Code)
	1 and 2 Health a tem 27 to		BEULAH J. GRAHAM	1 (NIFE) 4009	WOODRIDGE RD	BALTIMO	RE MD 21229
J.			20a. Method of Disposition	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place)	Date 200	. Location - City or Town, State
E	mit. Pages ertment of t ortant: If its injury or or		1 ■ Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	GARRISON	FOREST 12.00	3.05 ON	JINGS MILLS MD
Baltimore,	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service License	ve VA	2. Name and Address of Facility NUGHN C. GREENE FI		
	₹0 = i d		Caushin ( )	51	51 BALTO, NATL' PIKE	BALID. N	10 21229
				cations that caused the death. Do not en e cause on each line.		c or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	SEPTIC SHO	CK		2 d-Ays
1	/Medical Examiner		resulting in sealing	Due to (or as a consequence of):			*14000
*		<u>-</u>	Sequentially list conditions, if any, leading to immediate	URINARY TRA	ACT INFECTI	02	DAys
	uted 1 Insit		Cause (Disease or injury				
Ċ,	exect n and ial-tra	Examine	that initiated events cresulting in death) Last	Due to (or as a consequence of):			
68760,	cate be executed physician and the burial-transit	dical	L d				
	tifica ng ph as th	Medi	IC CCIAL C				
Вох	eath certifi attending   I for use as	an/	23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delivery
	The law requires that the death certify the bes been signed by the attending tage? Should be detached for use as	Physician/Me	in the past 12 months?  1  Yes 2 No		Other (specify)		Month Day Year
P.0	that the	P.	9 ☐ Unknown  Part II. Other significant conditions con	tributing to death but not regulting in the	andarhina agusa gwan in Part I	23a Did tobac	co use contribute to the cause of death?
S,	ires the signer to the d	þ			· · ·	1 ☐ Yes	-
Ö	w requir been si should	etec	CORONARY AI			los emen	- 7
Records,	: The law cete hes l page 2 s	Completed by	CARPIOMYOP	A7 H Y		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
ā			OF Was are referred to a street			1 ☐ Yes 2 ☑	
Vital		o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:	Othor	ath Check only one	2 Flori (2 1)
o	Phys or this aral di	-	27. Manner of Death	1 Inpatient 2 ER/Outpatien 28a. ate of Injury 28b. Time of	f 28c. Injury at	28d. Describe how in	e 6 ☐ Other (Specify)  njury occurred
on	nding Ph ith. :: After thi e funeral	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐ No		
Division	i or Attending after death. Director: After in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number,
Ö	tal or s afte al Dir ed in	Cert	Tomodo	Building, etc. (Specify)		Chy of Yours, S	ia(e)
	e Hospital or At 124 hours after o e Funeral Direc letely filled in by		(Check only 2 Medical Examin	ician: To the best of my knowledge, deat ser: On the basis of examination and/or in	h occurred at the time, date and place vestigation, in my opinion, death occurrence	a, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical	one)  29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, Day, Year)
	Twit oo		abel Hat	MiD	P17604	290.	EC. 0 2005
ı	12						, L. 30
0			ABOUL FATTAH	mpleted cause of death (Item 23a) (Type,		RE INA	21229
1	Sta	ite	31. Date filed (Month, Day, Year)	32 egistrar's Signature	שוויים אור אוריים	I'V PIV	
43	Registr		TIECO 6 200	15 % M	2000		

DHMH 17 Rev 1/2001

JOHN, GRAHAM

State of Maryland / Department of Health and Mental Hygiege Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** Mcclain 28 39:33 rancis 05 /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner A 5. Social Security Number VA ast birthday) If Under 1 Year edical If Under 24 Hrs. 8. Date of 8. Date of Birth (Month, Day, Yea 07.31.193 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 1 M 2 □ F 216 · 28 · 0394
Usuel Residence of Decedent 74 Director MD permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: If flem 27 le marked other than "naturel", or hems 23e or 28e-1 show 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Director NA 1 N Vas 2 □ No MD BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 811 COOKS LANE 21229 USA Funeral 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1/2 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 🗗 No Specify: Specify: Be Completed by 3 Nidowed 4 □ Divorced BLACK. 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STOCK CLERK GIANT GRADE 7 14 NIA 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) GARNER ALBERT ETHEL HAMILTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CT., RANDAUSTOWN, 3101 JULIAN CATHY GARNER DAUGHTER MD 21133 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Injury or 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING MEMORIAL PARK 12:05:05 RANDAUSTOWN, MD 21. Signature of Fune at Service Licens VAUGHN C. GREENE FUNERAL SERVICE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Prostate Cancer Meta Static years Examiner Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death.

To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medicai Due to (or as e consequence of) Part II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of death? 3 ☐ Probably 4 ☑ Unknown 1 Yes 2 No Mellixus abetes Be Completed 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? Blonary orally disease completion of cause of death? Hypertension TO Yas 22 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28e. Date of Injury (Month, Dey Year) 27. Maryler of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Phyeiclan: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD P18659 30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) 10 N. Greene St., Baltimore, MD LIANG, MS TEPHEN 31. Date filed (Month, Day, Year) 32 Registrer's Signature State 6 Registrar

			For State Registrar	State of Ma	aryland / [		artment of H tificate of				giene Reg. No.	005	39269
	Di		1. Decedent's Name (First, Middle,	Last)	<u>-</u>					2. Date of De		Year	3. Time of Death
ı	Physicia /Medic		Margaret	Hines Gau	ldin					Novemb	er 24	1, 2005	1:40p M
	Examin		4a. Facility Name (If not institution,	give street and number)			4b. City, Town, o	or Location	of Death		1	County of Dea	
			Frederick Vill				Catons					ltimor	
	Funeral		,	6. Sex 7. Ag 1 ☐ M 2 ☑ F	e (In yrs. last bir	rthday) Yrs.	If Under 1 Year Months Days	Hours		8. Date of Bir (Month, Da	ay, Year)	C	thplace (State or Foreign ountry)
	Director		218-42-2537 Usual Residence of Decedent		86					May 16	, 191	9 Ire	land
	ow or	Ì	10a. State 10b. County		10c. City, Tow	m or Lo	cation						10d. Inside City Limits
	Mary Fed	ţ	Maryland Hōward	l	Ellico	tt (	City						1 ☐ Yes 2 ☐XNo
	r 286	Directo	10e. Street and Number				10f. Zip Code				10g. Citiz	en of What Co	ountry?
	th wit	aiD	4501 Worthington	Manor Way			21043				Ire	eland	
	deal	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. V	Was Decedent of H	Hispanic O	rigin? (Spe	city Yes or No	p- 1	4. Race - Ame Black, Whi	
98	tied within 72 hours after death with the Maryland Hygione. Ither than "natural", or Items 23e or 28e-f show ant, the Medical Examinat must be notified at		1 Never Married 2 Marrie	If Yes, Give	No		Yes 22 No			,		Canaihu	
Ö	ural',	d by	3 ⅓Widowed 4 □ Divorced	Year or Dates:	160	Danne	teette Ulevel Occur					VV	hite
7	n 72 "nai	Completed	15. Decedent' (Specify only highest	grade completed)		(Give	lent's Usual Occup kind of work done DO NOT use retire	during mo	ost of workin	ng	I OD. NI	nd of Business	industry
12	with ene. ther	mo	Elementary/Secondary (0-12)	College (1-4or		rect	. Care	,			Nur	sing	
0	tiled Hyg other	a	17. Father's Name (First, Middle, L	ast)				18. Moth	her's Name	(First, Middle	, Maiden	Sumame)	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental hygiene. Is marked other than "natural", or Items 23e or 28e-f show sumatic event, the Medical Examinar must be notified at	To B	John Hines					Sop	hia	Hines			
ar <sub>2</sub>	and halls ma		19a. Informant's Name/Relationsh				ig Address (Street				•		
Σ.	and and n 27		Peggy Ann Decker	- daughter			R Dutton						
ore	of Hi of Hi If Iter		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from State	20b. Place o	f Dispo	sition (Name of natory or other plac		_	ate	20c. Lo	cation - City or	Town, State
altimore,	Pag tment tent: jury o		' 4 ☐ Donation 5 ☐ Other (Sp	ecify)			Memorial P			/2005		ridge,	
Bal	permit. Pages 1 and 2 should be Department of Heatilb and Menta Importent: If Item 27 its marked any injury or other traumatic av 00029.		21. Signature of Fundral Service L	icensee		22	Name and Addre Jary L. F 7250 Wash	ess of Faci Kaufm ningt	ian Fu on Bl	neral vd., E	Home 1kric	at MMP Ige, MD	, INC. 21075
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caused only one cause on each li	d the death. Do	not ente	er the mode of dyir	ng, such a	is cardiac o	r respiratory a	rrest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	FAIL	ARE TO	J	HRIVE						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):							
		<u></u>	Sequentially list conditions, if any leading to immediate	b. Due to lor as	a cons uence	offic							
	ited Insit	mine	Cause (Disease or injury										
Ċ.	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence	of):							-
8760,	icate be executed physician and s the burial-transit	dlcai		d									
9	tifica ng ph as th	ledi							- · · · · · · · · · · · · · · · · · · ·				
Вох	eath certific attending pi	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2 Petal death	1 3□	Ectopic pregnance	v			2	3d. Date of de	
	ne dea the att	Physician/Me	in the past 12 months?  1 Yes 2 No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)					Month	Day Year
<u>о</u>	that the de led by the detached	Phy	9 ☐ Unknown  Part II. Other significant condition	ne contributing to death to	out not reculting i	n the u	adortvina cauco an	von in Part	· 1	23e Did	obacco us	e contribute to	the cause of death?
ds,	es be	d by	COPD	to contributing to count i	out not roouting t	11 (110 (4)	idenying addoc gri	voir iii r care		18			robably 4 Unknown
Ö	w requir been si should	etec								24a. Was		24h Were a	utopsy findings available
Record	he lav e has	Completed								auto	psy ormed?	prior to death?	completion of cause of
Vital		e C	25. Was case referred to medical					26 Play	no of Dooth	(Check only	25 10	1 L Yes	2 No
	Physician: r this certificatal director,	0	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ☐ ER/Ot	utpatien	t 3 DOA Ott	200				Other (Spe	cify)
jo	ਦ € ਫ਼	n: T	27. Manner of Death	28a. Date of Inju	ury 28b.	Time of				8d. Describe			
<u>o</u>	ttending Ph death. stor: After th	atio	1 Natural 5 Pending 2 Accident investig	ation	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,ui y		Yes 2	□No				
Division of	or Attendate death Director:	Certification:	3 Suicide 6 Could n 4 Homicide determine	ned 286. Place of Iti	jury - At home, fa tc. (Specify)	arm, str	eet, factory, office		2	28f. Location ( City or To		Number or R	ural Route Number,
Ω	urs af urs af rad D								<u> </u>				
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	edical		g Physicien: To the best Exeminer: On the basis of and manner st	of examination ar								
	To the within 2 To the complet	Me	29b. Signature and title of certifier	C PL	endir	15	10 29c. Licens	se number	1		29d. Date	signed (Mont	h, Day, Year)
)	01		> RTEEU	× 131		0;	D	503	03		)	1/25	15
1	0		30. Name and address of person v	who completed cause of c	death (Item 23a)	(Type,	Print)	,	Mt	212	28	-Ros	LEO E
	v. Sta	te	31. Date filed (Month, Day, Year)		rar's Signature	UT	I ONDAILLE	٠	עווע	~10	- 0	FERN	ANDEZ MY
	Registi		DEC 0 6 2		· B A	1030	les .						

State of Maryland / Department of Health and Mental Hygiene O O

					Cer	tificate of	Death	Re	iene 0 0	5 3927
Physician /Medical		eme (First, Middle thy Gosn						2. Dete of Death Month November	Day \	3. Time of Dea 05 6:15 Pl
Examiner		e (If not institution		number)			4b. City, Town, or l	ocation of Deeth	4c. County of	
	Augsbu	rg Luthe	ran Home				Lochearn	1	Baltim	
Funeral Director	5. Sociel Securit 213-28-	5944	6. Sex 1 □ M 2D	7. Age (In yrs.	lest birthdey) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Dey, Oct. 4,	1906	9. Birthplace (State or For Country) Maryland
``	Usuel Residence	e of Decedent		10c C	ity, Town or Lo	cation				10d. Inside City Li
A Maho		Balti	moro		isterst					1 ☐ Yes 2 Z
28a-f	10e. Street and		LIOIC	I.C.	TOCCI OC	10f. Zip Code		10	Og. Citizen of Wh	at Country?
	10e. Street and								U.S.A.	,
a 23	6 Putti		12. Wes D	ecedent Ever in U	J.S. 13. V	21136 Ves Decedent of	Hispenic Origin? (S	pecify Yes or No-		- American Indian,
Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Evaniner must be notified at once.  To Be Completed by Funeral Director	1 Never M	arried 2□ Marri d 4□Divorced	ed 1 Tes	Forces?	11	Yes, specify Cut ☐ Yes 2 No	ben, Mexican, Puert	o Rican, etc.)		White, etc. White
ygiene. Ner than "natural", o it, the Medical Exan Completed by	7	15. Decedent		, Duito.	16a. Deced	ent's Usual Occu	petion		16b. Kind of Busi	iness/Industry
iet in in	(S	pecify only highes	t grede complete		(Give life. L	kind of work done OO NOT use retire	during most of wor	king		
that the	Elementery/S	econdary (0-12)	Colleg	e (1-4or 5+)	Ноп	emaker			Own Ho	me
d other event, Be C		me (First, Middle,	Last)		100		18. Mother's Nan	ne (First, Middle, A		
Mental arked c atic ev	Edward	Norris					Lizzie	Pear1		
T mer	19a. Informent's	s Name/Relations	nip (Type, Print)				and Number or Ru			
uith a 27 is r trau	Patric	ia M. Bu	rnett	(Daughte	r) 6 Pu	tting Wa	ay Reist	erstown,	Marylan	d 21136
or other	20a. Method of	Disposition 2 Cremation	3 Removal fro	20b. om State	Place of Dispo cemetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Location - C	ity or Town, State
tant:		on 5 Other (Sp		Мо		Cemeter				wn, Marylan 1 Directors
Depar mpor any Ir	21. Signature of	Funeral Service	Licensee							aryland 211
Medical xaminer	Immediate Cau disease or cond resulting in dea	dition	e		or es e conseq		ovas im s	Disca	se.	1
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ing physician and e as the bunal-transit		e or Injury ents	c		or es e conseq or es e conseq					
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_ s •		e or Injury ents th) Last	d	Due to (	or es e conseq	uence of):	iven in Part I.		n autopsy	
is been signed by the attending to 2 should be detached for use as pleased by Physician/Me		e or Injury ents th) Last	c	Due to (	or es e conseq	uence of):	iven in Part I.	1 □ Yo	n autopsy	3 Probably 4 Unk 24b. Were autopsy findin available prior to completion of cause of death?
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Torrey Lee Garland UNK 05-08065 d1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5, perlamielle Edwards (851, 1/19/06 TI State of Maryland / Department of Health and Mental Hygiege 15 Certificate of Death 2. Date of Death I. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Torrey Lee Garland November 30, 2005 1:23 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 2, 15 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 014 60 3100 **Funeral** Days **X**M 2□ F Hours Yrs 1979 Maryland Director 26 Usual Residence of Decedent 10b. Count 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "naturel", or Iteme 23a or 28e-f show The Medical Examinar Investigated at Baltimore 1 Yes 2 □ No Maryland N/ADirect 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 4201 Penhurst Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiens. Important: If item 27 is marked other than "na eny injury or other traumatic event, Ite Medic once. (Give kind of work done do life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Private Company Construction Worker 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Timothy Garland, Sr. Delores Lea 19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code and Dorothy Garland/Grandmother 4201 Penhurst Avenue Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 12/05/05 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Liby see 5240 Reisterstown Road Baltimore, Md21215 Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only one cause on each line. Immediate Cause (Final aunshot wounds Physician multiple disease or condition resulting in death) /Medical Due to (or as a consequence) f): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Sit Exami certificate be execut attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? V2Yes 2□ No 1 Yes 2 🗌 No Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 No Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending -29-05 subject shot 1 Yes 2 No death. investigation <u> 39:</u>10 To the Hospital or Attend within 24 hours after death. To the Funerel Director: A completely filled in by the fu 2 Accident filled in by the 3 Suicide
4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 3 city or Lown State) Stree 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) November 30, 2005 OCME 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Patricia Aronica-Pollak, M.D. 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)
DEC 0 6 2005 32. Registrar's Signature State Registrar

			For State Registrar	State of Ma	•	epartment of Certificate o			giene Reg. No.	005	39272
	Physicia		Decedent's Name (First, Middle, La		ENT			2. Date of De. Month DECEMB	Day	Year 2, 2005	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, giv			4b. City, Town	or Location of Deal	th	_	county of Deat	
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	Director		Usual Residence of Decedent	A	81 ***	- Location		Sept 1:	3, 19	24 Ne	W York  10d. Inside City Limits
	Aarylar f show	ō	10a. State 10b. County Maryland Baltimor	o County	10c. City, Town o	OWSON		*			1 ☐ Yes 2 ☑ No
	or 28a-	Director	10e. Street and Number	e country		10f. Zip Code	)		10g. Citize	en of What Co	
	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-f show solical Examinat must be notified at	Funeral C	800 Southerly R	Allifed Forces?		13. Was Decedent o	21286 f Hispanic Origin? (Suban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14	USA 4. Race - Ame Black, White	ncan Indian, e, etc.
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Ε.	should nd Men marke umatic	ဥ	Cecil  19a. Informant's Name/Relationship (	Clark (Type, Print)	19b. N	lailing Address (Stre		T. Mol	-	,	Zip Code)
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ore	ages 1 nt of He : If iter		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State		isposition (Name of crematory or other p	1	Date		ation - City or	
altimor	permit. Pages Department of Important: If I any injury or once.		4 □ Donation 5 □ Other (Special 21. Signat // of Fundal Society) as	7 00		Mount Ceme	ress of Facility				Maryland
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١	5		30. Name and address of person who	completed cause of de	eath (Item 23a) (T		or T Mat Sout TT		(	1-10	
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			1 - State Registrar	ate of Maryland		artment of Ho			giene 05	39273
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	n 24 h	edicai	(Check only 2   Medicel Exeminer: (	In the basis of examination of manner stated.	on and/or inv	estigation, in my opi	inion, death	occurred at the time,	date and place, and due	to the cause(s)
v	To the vithing To the comp	Me	29b. Signature and title of certifier	Δ -		29c. License			29d. Date signed (Mont	h, Day, Year)
•			16/Min	, IND.	12a) (T 1	1)2	1913		11/8/05	
	3		30. Name and address of person who comple	415 Wash	upton	Ave., Cl	restert	Town, MI	21620	
	Sta		31. Date filed (Month, Day, Year) DEC 0 6 2005	ed cause of death (Item 2 415 Wash 32 Registrar's Signatu	Ana	2 A B		1. 2		
	Registr	ar	DEO 0 0 7003	JOS CARD ST	and the same					

State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Irene Straitz Hittel 28, 2005 Nov. 2:01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Caton Manor Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 ☐XF Yrs. Director 85 11/28/1920 217-14-0721 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating to motified at 1 X Yes 2 ☐ No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3614 Hineline RD. 21229 USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Exam in 2008. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: White 3 X Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frederick Straitz Martha Schmidt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Tuxford / Daughter 3614 Hineline Rd., Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mem Park 12/01/05 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home atMeadowridgeMP, Y 7250 Washington Blvd., Elkridge, MD 21075 cma-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Metastatic months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed anding physician and use as the burial-tran Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Discort 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗖 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-40521 November 28, 2005 elguy 30. Name and address of person who o impleted cause of death (Item 23a) (Type, Print) 325 that pital Anive DR. PCHAREY

New Burnie, MA 21061 31. Date filed (Month, Day, Year) 32: Registrar's Signature State DEC 0 6 2005 Registrar

			For Steta	State	of Maryla	•	artment of I				2005	39275
			Registrar  1. Decedent's Name (First, Middle	l act)		Cei	illicate of	Deali		2. Date of Dea	Rag. No. U U U	3. Time of Death
	Physicia	an			n h	U.	ınt			Month Novembe	Day Year	
	/Medic Examin		Bernard  4a. Facility Name (If not institution	Jose		110	4b. City, Town,	or Location		vo vembe	r 25, 2005	
	Examin	eı	Manor Care				Cato	nsvil	l1e		Baltimo	re
	Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under		8. Date of Birt (Month, Da		irthplace (State or Foreign Country)
	Director		213-28-6219	1⊠M 2□ F	74	Yrs.	Wortins Days	110013		March 4		ryland
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. (	City, Town or Lo	ocation					10d. Inside City Limits
	faryli sho	ō										1√2 Yes 2 □ No
	289-1	Director	Maryland N/A  10e. Street and Number		Ba	ltimore	10f. Zip Code				10g. Citizen of What 0	Country?
	Mith Ba or	١	1244 S Grantley	St			21229	)			USA	,
	72 hours after death with the Marylan "natural", or items 23a or 28e-1 show alsal Evaniner must be notified at	Funeral	11. Marital Status	12. Was De	cedent Ever in	U.S. 13.	Was Decedent of	Hispanic O	rigin? (Spec	cify Yes or No	- 14. Race - An	nerican Indian,
>	or ite		1 Never Married 2 Marr	ied 1 ∏ Yes	2 No		If Yes, specify Cub 1 ☐ Yes 2 ☑ No			ticari, etc.)	Black, Wh	
3	ural',	d by	3 Widowed 4 Divorced	Year or	Dates:Kore	an						White
5	"natu	Completed	15. Deceden (Specify only highe		)	(Give	dent's Usual Occu kind of work done DO NOT use retire	durina mo:	st of workin	g	16b. Kind of Busines	s/Industry
7	withir	du	Elementary/Secondary (0-12)	College	(1-4or 5+)		esman	, d			Time C-	
7 7	be filed within 72 hours after death with the Maryland Hygiene. Indepty be no content of them 23a or 28e-f show to other than "natural; or items 23a or 28e-f show event, the Medical Evanimer must be notified at		17. Father's Name (First, Middle,	Last)		Sale	-Silidii	18. Moth	er's Name	(First, Middle,	Tire Co Maiden Sumame)	шрапу
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Maralla Hygbert. Department of Health and Maralla Hygbert. Instruction: I filem 27 is marked other than "natural; or items 23a or 28e-1 show any injury or other traumatic event, II.— Medical Evantment must be notified at once.	To Be	William		Hunt			C1a	ıra_		Berger	
2	should and Men marke umatic		19a. Informant's Name/Relations	hip (Type, Print)		19b. Maili	ng Address (Stree	t and Numb	er or Rural	Route Numbe	er, City or Town, State,	Zip Code)
Ž	and 2 ealth a n 27 is		Margaret G. Hur	nt (Wife)		1244	S. Grant	:ley S	St., B	Baltimo	re, MD 212	29
ב ב	of He of Herrican		20a. Method of Disposition	2 Pomoval from	20b	. Place of Dispo cemetery, cre	osition (Name of matory or other pla	109)	Da	ate	20c. Location - City of	r Town, State
	Pages nent of h ent: If ite ury or of		1 🔀 Burial 2 🗍 Cremation `4 ☐ Donation 5 ☐ Other (S		II State Me	adowric	natory or other pla ige Memor Park	rial	11/30	/05	Elkride,	Maryland
ğ	permit. Departr Imports any inji		21. Signature of Funeral Service	Licensee			2. Name and Addr				ark Funera	
۵_	207 2 2		1/2								ore, MD 21	
	Physician /Medical		23a. Pinter the disease, or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.	ul ste	V	ing, such as Les SO		respiratory ar	rest,	Approximate Interval Between Onset and Death
	Examiner		,	Due to	o (or as a cons	equence of):	0					
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a cons	equence of):						-
	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .								
Ś	be executed ician and burial-transit		resulting in death) Last	Due to	o (or as a cons	equence of):						
0000	cate be executed obysician and the burial-transit	edical		d								
ŏ	entifica ing pl	Med	IF FEMALE:	T								
ממ	ath cattend	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐Live	utcome of preg birth 2 ⊟Fe gnant at time o	etal death 3	☐Ectopic pregnanc☐ Other (specify) _	у			23d. Date of d Month	elivery Day Year
j	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unk		i death 31	Other (specify) _					
, L.	The law requires that the death certificate ite has been signed by the attending phys age 2 should be detached for use as the	by	Part II. Other significant condition	ons contributing to	death but not r	esulting in the u	inderlying cause gi	ven in Part	I.	23e. Did to	obacco use contribute	to the cause of death?
cords,	w require been si should b	Completed		160	10	(in				24a. Was	an 24h Worn	autoney findings available
ב ב	ne lav has ge 2 a	ld li		11011	ici pen	Sun				autor	rmed? death?	autopsy findings available completion of cause of
VIE		e Co	25. Was case referred to medica					26 Plan	o of Dooth	(Check only o		s 2 No
	Physician: r this certific ral director,	o B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	hor	/		dence 6 Other (Sp	ecify)
5	ding Physician: h. After this certific funeral director,	n: T	27. Manner of Death	28a. Dat	e of Injury onth, Day Year)	28b. Time o					now injury occurred	,,
VISION	ath. r: Aft	atlo	1 Natural 5 Pendir 2 Accident investi	gation	,, Duy 100.	,,		Yes 2	]No			
<u> </u>	r Atte	ertification:	3 Suicide 6 Could 4 Homicide determ	not be nined 28e. Pla buil	ce of Injury - At	home, farm, st	reet, factory, office		2	8f. Location (5 City or Tox	Street and Number or I vn, State)	Rural Route Number,
2	urs aft	O										
	To the Hospitel or Attending within 24 hours after death.  Jo the Funeral Director: After completely filled in by the fune.	edical		Exeminar: On the							cause(s) and manner a date and place, and du	
	withir Jo th comp	> Me	29b. Signature and title of certifie		44.2		29c. Licen	se number	7 -		29d. Date signed (Mor	nth, Day, Year)
	10	1			MD		1	127	569		11/28/0	5
16	24		30. Name and address of person	who completed ca	use of death (I	tem 23a) (Type,	Print) 2C	0	Co.	T	11/28/0 ree Pd	7/120
Γ,			31. Date filed (Month, Day Year)	2000000	Registrar's Sig	nature As	Angella 2	0	1 cen	- 11		01000
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			For State	State o	f Marylan					and W	entai ny	giene	005	39276
			* Registrar			Cel	rtificate	Of L	Jeath			Reg. No:≃	000	
	Physici	an	Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Edward Rudolph Ho								HotemB	ER 3	30 2005	66-15AM
	Examin		4a. Facility Name (If not institution, give	re street and nur	mber)	_	4b. City, T		~				ounty of Deat	
			4a. Facility Name (If not institution, giv PACTIMER WASHING	ITON Wh	BOXUAL (	ENTE	2 4	- 4	4 Bu		E	AF	INE F	FRIMPEL
	Funeral	7		Sex 14∆0 M 2□F	7. Age (In yrs.	• • •	If Under 1 Months	Year Days	If Under :	24 Hrs. Min.	8. Date of Birt (Month, Date) 1-26-19	h y, Ye <i>ar)</i>	9. Birti Co	hplace (State or Foreign untry)
	Director		217-16-3119	PE W 201	81	Yrs.					1-26-19	924	l	MD
	pu *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation							10d. Inside City Limits
~	anyla •ho	č	,	1 1										1 ☐ Yes 2√∑ No
<b>\leq</b>	Ne N	Funeral Director	MD Anne A	rundel		Glen B	urnie 10f. Zip C	Do do				10~ Chi-	on of What Co	
219A1	with 1	늅							•					untry :
5	s 23	iai	518 Wimmer Road	12 Was Dass	ndont Cuer in LL	S 12.1		2106		ain? (Can	of Vac of No		.S.A.	econ Indian
Q	er de Itam	ŭ	11. Marital Status	Armed Fo	edent Ever in U.	.5.	f Yes, specif	y Cuba	n, Mexican	, Puerto l	cify Yes or No- Rican, etc.)		Black, White	
36	hours after death with the Maryland turet', or Itams 23a or 28e-f ehow at Examiner must be notified at	by F	1 ☐ Never Married	1 XYes If Yes, Giv Year or D	/e ates:		1 □ Yes 🛣	No	Specify:			5	Specify: V	Vhite
16 d	hou	ed	15. Decedent's E			16a, Deced	ient's Usual	Occupa	ıtion			16b. Kind	d of Business/	ndustry
15	n "na	piet	(Specify only highest gr	ade completed)	(45-)	(Give	kind of work OO NOT use	done d retired,	uring most	t of workii	ng			,
HR 21215-0036	iene.	Completed	Elementary/Secondary (0-12)	College (1	1-4015+)	Bricl	klayer					Con	tractin	19
	Hyg othe	Bec	17. Father's Name (First, Middle, Last	)					18. Mothe	ır's Name	(First, Middle,			*
lan	ked be	To B	Edward Patrick Ho	rrigan					Mar	у Мо	ntier			
$\mathcal{A}$ $\mathcal{K}$	shou nd M mar	_	19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	ng Address (	Street a	nd Numbe	r or Rura	l Route Numbe	r, City or	Town, State, Z	ip Code)
$\mathcal{D}\mathcal{UQRQ}$ Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28e-1 ehow eny injury or other treumatic event, the Madical Examiner must be notified at once.		Sarah Horrigan /	Wife		518	Wimme	r R	oad;	G1en	Burnie	, MD	21061	
ã Š	s 1 a f Hea item othe		20a. Method of Disposition		1 0	Place of Dispo	sition (Name	of of			ate		ation - City or	Town, State
$\mathcal{MQR}$	age ent o nt: If y or		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State	n Haver	-			12-3	-2005	C1 01	n Burni	o MD
3 =	ertm ortar		21. Signature of Funeral Service Lice		DIC.						gleton			
S S	Ped drag		12611	1/	/ Mo						en Burn			
40	×		23a. Part 1. Enter the disease, or com shock, of heart failure. List only	plications that c										Approximate
	Plane in its		shock, or beart failure. List only Immediate Cause (Final											Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		(or as a conseq	The state of the s	CAN	استك	_					
	Examiner		- 1	Due 10 1	(or as a conseq	derice or).								
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	(or as a conseq	uence of):								
	uted	m tu	Cause (Disease or injury that initiated events											
Ć,	be executed icien and burial-transit	Examiner	resulting in death) Last	Due to (	(or as a conseq	uence of):								
760,	ate be executed nysicien and he burial-transit	cal	(	_ d										
68	ifficat g phy as th													
ŏ	eath certifica attending ph for use as th	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregna	incy	Ectopic pred					23	d. Date of deir	very
<b>m</b>	death	icia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregn	ant at time of d		Other (spec						Month	Day Year
0.	by the	hys	9 ☐ Unknown	9□ Unkno	own									
ű.	v requires that the death certifica been signed by the attending ph should be deteched for use as th	by Physician/Med	Part II. Other significant conditions	contributing to de	eath but not res	ulting in the ur	nderlying cau	use give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
ĕ	quire on sig uld b	ed t									1 🗆 Y	es 2 🗌	No 3□Pro	bably 4 Inknown
ပ္ပ	s been s shouk	Completed									24a. Was		24b. Were au	opsy findings available
æ	icien: The lav certificate hes rector, page 2	E o									autop perfor	med)	death?	ompletion of cause of 2 No
ta	en: tifica tor. p	Be C	25. Was case referred to medical						26. Place	of Death	(Check only or		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2510
<u> </u>	ysici is cer direc	To B	examiner?	Hospital: 1	npatient 2	ER/Outpatien	t 3 DOA	Othe			ne 5 ☐ Resid		Other (Spec	ufv)
Division of Vital Records, P.O. Box 68	Attending Physicien: The law requires that the death certifica readth: death.  •ctor: After this certificate hes been signed by the attending ph. by the funeral director, page 2 should be deteched for use as the	ī.	27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time of Injury	286	c. Injury Work	at		8d. Describe h			
<u>.</u>	ath. r: Aft	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation		in, Day reary	nijary	М		es 2 🗆 N	No				
<u>×</u> :	Atte	iii c	3 ☐ Suicide 6 ☐ Could not be determined	288. Place	of Injury - At ho		eet, factory,	office		2	8f. Location (S City or Tow		Number or Ru	ral Route Number,
Ö	s afte el Dire	Certification:	/	Danish	ng, cts. (opcon)	,,						., 0.0.0)		
	hour hour uner ly fills	cai	29a. Certifier 1 Certifying Pl	nysician: To the	best of my kno	wiedge, death	occurred at	the tim	e, date and	d place, a	nd due to the o	ause(s) a	nd manner as	stated.
	To the Hospital or Attending Physicien: The lawithin 24 hours after death. λο the Funerel Director: After this certificate hes completely filled in by the funeral director, page 2.	Medical	one)	and man	ner stated.	non and or my					d at the time, t	ate and p	ace, and due	to the cause(s)
	To the Hospital or Attending I Avithin 24 hours after death. Ye the Funerel Director: After completely filled in by the funer	Σ	29b. Signature and lifte of certifier			. 4 . >			number	110			signed (Month	
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	U I		30. Name and address of person who	completed caus			Print)	1 5		7.1	. 0			30 2005
		٩	TURBAJO	501	Hes	1	( D)	14		cre	en b	Ursi	re Tr	1971061
(5)	Sta		31. Date filed (Month, Qay, Year)	32 R	egistrar's Signa	ture	All D							
***	Registr	ar	DFC 0 6 20	95 25	Jak Sand John State	A STORE								

					⁄lental Hygi Re	ene g. No. 05	39277
	Physicia /Medic	al	Decedent's Name (First, Middle, Last)  Lois Ann Hunter  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		29 Year 2005	3. Time of Death 6:26 P M
	Examin Funeral Director	er	Baltimore Washington Medical Ctr.  5. Social Security Number	Glen Burnie	8. Date of Birth (Month, Day, 11–17–19	Anne Arui	place (State or Foreign
	o_	tor	Usual Residence of Decedent  10a. State		11-17-19		PA  10d. Inside City Limits  1 □ Yes ※□ No
	th with the 23a or 28e ast be noti	Funeral Director	10e. Street and Number 510 Mayo Road	10f. Zip Code 21061	10	g. Citizen of What Cou	ntry?
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  By injury or other treumatic event, the Medical Examinar must be notified at ODG.	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Wolds Pear or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
0-0-1	rithin 72 ho ne. nan "natu a Medical	Completed	(Specify only highest grade completed) (Giv.  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation a kind of work done during most of work DO NOT use retired)	ting 16	6b. Kind of Business/Ir	•
ומוומילו	uld be filed w fental Hygier rked other th tic event, th	To Be Cor	9 Ho  17. Father's Name (First, Middle, Last)  Vernon Reno Kapp		e (First, Middle, Mi		mer
, ivially	and 2 shot baith and A n 27 is ma		Mrs. Deborah Agee/daughter 510	ing Address <i>(Street and Number or Rur</i> Mayo Road, Glen Bu			Code)
	Pages 1 tment of H tent: If ites jury or oth		'4 Donation 5 Other (Specify) Chesapeal	ke Cremation 12/		Oc. Location - City or To	
ם	permit Depar Impor eny in		Dara Callas M01364 1	2. Name and Address of Facility Si Second Ave SW Gle			ne P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	ater the mode of dying, such as cardiac Aonic Andrea entensi		st,	Approximate Interval Between Onset and Death
ı	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	entension)			
O. DOX 0	the death certifi by the attending ached for use as	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive	ery Day Year
corus, r	equires that en signed b ould be deta	by	Part II. Other significant conditions contributing to death but not resulting in the to	(/ - 0	23e. Did toba 1 ☐ Yes	2 No 3 Prot	
	n: The law re licate has be rr, page 2 shi	Completed			24a. Was an autopsy performe 1 Yes 2	prior to co death?	psy findings available mpletion of cause of 2 No
0 119	hysicie this certi	To Be	25. Was case referred to medical examiner?  1   Yes 2   Nó	nt 3 DOA Other: 4 Nursing Ho	h <i>(Check only on</i> e) me 5□Re <i>s</i> iden	ce 6 □Other (Specif	у)
VISION	To the Hospitel or Attending Physicien: The law within 24 burus atter death.  To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2 or	Certification:	27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined learning of the suite of the s	Work? M 1 □ Yes 2 □ No	28d. Describe how 28f. Location (Stre	et and Number or Rura	tl Route Number,
Ś	ospitel or hours afte unerel Dira ly filled in t		building, etc. (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, dear	th occurred at the time, date and place.	City or Town,	State)	tated
	To the H within 24 To the F complete	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	29c. License number		e and place, and due to de la	
		<b>t</b> o-	30. Name and address of person who completed cause of death (Item 23a) (Type 45 To 7	Print) Ro Kattie #	wy Gu	LEN BU	PAR MI)
	Sta Registr		SZ. Registral's Suprature		4		

	For State Registrar	;	State of I	Marylan		rtment of H tificate of L			R	eg. No.	005	39278
Physician	1. Decedent's Name (First	t, Middle, Last)	Нооре	ar.					Date of Dear Month ECEMbe		2005°	3. Time of Death 10:20a M
/Medical	4a. Facility Name (If not i					4b. City, Town, or	Location of				ounty of Deat	_1
Examiner	Oak Cres					Parkvil				Ba	altimo	re
Funeral Director	5. Social Security Numbe 212-28-546	3 101	M 2 F 7.	Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. A	Date of Birth (Month, Day pril 5	, 19:	9. Birt Co Mai	hplace (State or Foreig runtry) cyland
death with the Maryland ms 23s or 28s-f show if must be notified all neral Director		County 31timore			y. Town or Lo					_		10d. Inside City Limits 1 ☐ Yes 2 No
with the Ma s or 28s-f s be notifie Directo	10e. Street and Number					10f. Zip Code			1	_	n of What Co	ountry?
ath w	8800 Wal				0 10	21 234	0-1-	-1-0/04	V N-	US		rices Indian
art, or ite	11. Marital Status  1 Never Married  3 Widowed 4	2□ Married	2. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? No	1	Was Decedent of Hi fYes, specify Cuba I□Yes 21XXNo	spanic Orig n, Mexican, Specify:	gin / (Specir , Puerto Ric	y Yes or No- an, etc.)		Race - Ame Black, Whit pecify:	
na na lete	15. I (Specify or Elementary/Secondary		completed) College (1-4	or 5+)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most	of working			of Business/	,
I Hygiene. other then ent, tre M	17. Father's Name (First,		4		Home	Maker	18. Mother	r's Name (F	First, Middle,		umame)	3
T S G S T	Clayland	Wi	lliams		10b Mailie	ng Address (Street a	Ger	trude	,	Boane	3	Zin Code)
	Mrs. Susan			Daughi		3.Box 58						LIP 0000)
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic ance.	20a. Method of Disposition  1 Burial 2 XCre 4 Donation 5	on emation 3 🗆 Re		20b. P	Place of Dispo emetery, crei	sition (Name of natory or other place	e)	Date	9	20c. Loca	ation - City or	
permit. P Departme importan any injur once.	21. Signature of Fund		0	,	22	. Name and Addres	ss of Facility	у			1050 \	York Road n,Md.21204
special and burial-transit cal Examiner	Sequentially list condition of any leading to immediate. Enter Underlying Cause (Disease or injurithat initiated events resulting in death) Last	ns, b.		r as a conseq r as a conseq								
To the Hospital or Attending Physicien: The law requires that the death certificate twithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the Empletely filled in by the funeral director, page 2 should be detached for use as the Empletel Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent prein the past 12 mon 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	mant		th 2 ∐Feta ntattime of d	Ideath 3	]Ectopic pregnancy ] Other (specify)	,			23	d. Date of de Month	livery Day Year
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To the Within To the Comp	29b. Signature and title	of certifier				29c. Licens						th, Day, Year)
10	30. Name and address	of person who con	mpleted cause	of death (Iter	m 23a) (Type	Print) knna Aculesa	1641 mon	6		Deco.	i solm	5, 200 5
IV	Anna mon		\$ 300	ualt	the t	Aculesa	10)	Pork	-11.0.	, Mi	> 2	1234
State Registrar	31. Date filed (Month, D		05 32. Re	gistrar's Sign	ature	parks						

12/105 10 200 r.

Anna Hooper

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death November 29 2005 **Physician** 0515 James R. Howe Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 22 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Days Hours 1**∑**M 2□F 55 Yrs 220-56-8242 1950 D.C. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at Annapolis 1X Yes 2 No Maryland Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 63 Spa Rd. 21401 USA death by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notit Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 271s marked other than "natural", or Item soy injury or other traumatic avent, the Mental page. 1 ☐ Yes 2 XNo 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Substance Abuse Counselor State Of Maryland 0 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James R. Howe Sr. Naomi Smith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nicole Howe (Daughter) 141 Faywood Ct. Apt E Glen Burnie, Md. 20b. Place of Disposition (Name of Besite) and a 1 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 12-3-05 Annapolis, Md. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wm. Reese & Sons Mortuary, P.A. 10048 821 West St. Annapolis, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Examiner The law requires that the death certificate be executed use as the burial-transit Herakis C Due to (or as a consequence ot): that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, the attending physicien hed for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown ፭ ete has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 20 No is after deam. ral Director: After this ceruination by the funeral director, p To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA . Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 Tes 2 No 2 Accident thin 24 hours after de the Funeral Directo 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical within 24 hor To the Fune completely fi and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0005763 Nov 2005 m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods 2001 medic 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 6 2005 Registrar

		1	1- For State of Maryland / Department of Health and I Certificate of Death		2°005	39280
	Physicia		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	Day O Year	3. Time of Death
	/Medic	al	Joseph Jakielski  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		2, 2005 4c. County of Deat	12:21 AM
	Examin	er	300 Sunflower Drive, Apt. 259  Bel Air		Harf	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth		
	Director		212-28-6943 X 76 Yrs.	8. Date of Birth (Month, Day, Y)	1929 Ma	hplace (State or Foreign huntry) ryland
	pue M	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	f sho	jo	MD Harford Bel Air			1 ☐ Yes 2 ☑ No
	r 28a-	rec	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Co	ountry?
	within 72 hours after deeth with the Maryland ene. then "natural", or items 23a or 28a-f show the Madical Exercites must be notified at	by Funeral Director	300 Sunflower Drive, Apt. 259 21014		US	Α
	er dee	uner	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whit	
36	rs afte	by F	1 XNever Married 2 ☐ Married 1 ☐ Yes 2 XNo If Yes, Give X 1 ☐ Yes 2 XNo Specify: Year or Dates:		Specify: W	hite
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and	ntal Hed ot	Be	17. Father's Name (First, Middle, Last)   18. Mother's Nam   John Stanley Jakielski   Anna			nek
Maryland	should nd Me mark matic	٢	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Ru</i>			
M	alth and 2: 27 is 27 is or trac		Brenda J. Cole, niece 1702 Laurel Brook	Rd. Fal	1ston, N	1D 21047
Ze,	of Hear		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20	c. Location - City or	Town, State
Ë	Pagement: Mant: Hant: Mant: H		4 Donation 5 Other (Specify) Metro Crematory, Inc. 12/0		Baltimor	e, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Deperment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural; or items 23a or 28a-f show appringuty or other traumatic event, the Madical Examinat mant be multified at ance.		21. Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility	of Maryla	and, Inc.	
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	Dhusisian		shock, or heart failure. List only one cause on each line.	. ,		Interval Between
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	Examiner		Sequentially list conditions b.			
,-	sit ad	iner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying			
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Box	ath cei tendir or use	an/	23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	ivery Day Year
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	0		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	MIN		
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4	Sta Regist	ate rar	DEC 0 6 2005			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 25, Year 2005 Month **Physician** William Jones 8:00PM November /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2737 Cylburn Avenue Baltimore N/A| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State of Country) | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** XXM 2□ F 213-32-8325 69 Yrs Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other then "netural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examinat must be notified at 1X Yes 2 □ No Directo Maryland N/ABaltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2737 Cylburn Avenue 21215 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 196 If Yes, Give Year or Dates: 196 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1960 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XXNo Specify: Specify: Black 1966 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore 1 0th Grade (0-12) College (1-4or 5+) Aircoil Company Rigger 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Jones Estelle C. Cook ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2737 Cylburn Avenue Baltimore, Maryland21215 Jean Jones/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 12/5905 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Garrison Forest Vet. Cem. Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris FuneralHome 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, MD21215 Carris Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** METASTATIC NON SMALL CELL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine been signed by the attending physicien and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ANEMIA 24a. Was an page 2 s autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this After the funeral of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director; / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0059107 M. D 2-1-2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IMA 上しいひ ANENUE BALTIMORE BERTY MEIGHTS 31. Date filed (Month, Par Gar) 2005 32. Registrar's Signature State 6 HARLIGHT. Registrar

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	Physicia	an	Decedent's Name (First, Middle)			-					Date of Death Month		əar	3. Time of Death
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ກັ	s 1 ar	1)	20a. Method of Disposition		20b.	Place of Dispo	sition (Nan	ne of		Date		c. Location - Cit		
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á	death e atte	lcian/M	in the past 12 months?	4 ☐ Pred	birth 2 Fet gnant at time of		Ectopic pr Other (sp					Month		Day Year
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ב'ה	w requires that the death certif been signed by the attending should be detached for use a:	by F	Part II. Other significant condition	s contributing to	death but not re	sulting in the u	inderlying c	ause given	in Part I.					e cause of death?
	requil	Completed								-	1 ☐ Yes	2 <b>2 1 1 1 1 1 1 1 1 1 1</b>	] Proba	ably 4 Unknown
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<u> </u>	n: Th ficate r, pag		OF Management								1□ Yes 2⊡			2 No
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5	g Phy er this ieral c		27. Manner of Death	28a. Date	e of Injury	28b. Time o		Bc. Injury a Work?				injury occurred	<i>ървспу</i>	)
NISION NISION	andin path. pr: Aft	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig	ation	nin, Day rear)	Injury	м		es 2□No					
<u> </u>	r Att	Certification:	3 Suicide 6 Could no 4 Homicide determin	led 289. Plac	e of Injury - At I ding, etc. (Spec		reet, factory	, office	_		Location (Stre City or Town,	et and Number o	r Rural	Route Number,
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	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours afterderath.  To the Funeral Director After this certificate has been signed by the attending, completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 ☐ Certifying (Check only 2 ☐ Medical E	Physician: To the xaminer: On the and ma	ne best of my kr basis of examin nner stated.	nowledge, deat nation and/or in	n occurred vestigation,	at the time in my opir	, date and pl nion, death o	lace, and occurred a	due to the cau t the time, date	se(s) and manne and place, and	r as sta due to	ited. the cause(s)
	Mithin Fo the	Me	29b. Signature and title of certifier					. License	number		290	. Date signed (M	fonth, £	Day, Year)
			Culnu S.	muli 1	MEDICAL	DOCTOR	-	RE	5-00	0		DECEMB	CR	2, 2005
	2		30. Name and address of person w											
	5		A DNAN MALIK, JOH				N. WO.	FES	TREET	, BALT	more,	MD 21	287	,
	Sta Registr		31. Date filed (Month, Day, Year)	G 2005	Registrar's Sign	ature	marke	,						

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of <i>rtificate o</i>		Mental Hy	giene	5 39283
98	Physici /Medi		Decedent's Name (First, Middle, La	attre =	Johnse	911		2. Date of De		Year 3. Time of Death
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	Funeral Director			ox ay F 7. Age	(In yrs. last birthday) Yrs.	Months Day			ay, Year)	Birthplace (State or Foreign Country)  VA
	e Marylan 8a-f show	Director	MD 10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits 1
	h with th		10e. Street and Number 2311 Homewood	Avenue		10f. Zip Code 21:	218		10g. Citizen of W	
9036	be filed within 72 hours after death with the Maryland tal Hyglene. Id other than "natural", or iteme 23e or 28e-f show event, tre Medical Exartifier must be recilised at	d by Funeral	11. Marital Status  1 Never Married 2 Married  3 🔀 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	lo	Was Decedent of the Yes, specify Control of the Yes 250	f Hispanic Origin? uban, Mexican, Pue lo <i>Specify:</i>	(Specify Yes or No erto Rican, etc.)		- American Indian, , White, etc. Black
21215-0036	within 72 h ane. than "natu	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation (de completed) College (1-4or 5	(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne during most of w ired)	vorking .	16b. Kind of Bus	siness/Industry
Ind 2	be filed tal Hygi d other event, I	Be	12th grade 17. Father's Name (First, Middle, Last	_		DOMES C.		ame (First, Middle	Other , Maiden Sumame	People Homes
Maryland	should and Men s marke numatic	2	Harold Sa 19a. Informant's Name/Relationship (	mple Type, Print)	19b. Mailir	ng Address (Stre	Anni et and Number or		Ames er, City or Town, S	State, Zip Code)
	D = 12 =		Mattie Lane-dau  20a. Method of Disposition	ghter	20b. Place of Dispo	sition (Name of	od Avenue	Baltimo	·	21218 City or Town, State
Baltimore,	Page ent o nt: if ry or		1 Burial 2 Cremation 3 4 Donation 5 Other (Special	y)	Baltimo		12	-7-03	Baltimo	ore, Md.
Bal	permit. Departm importar any inju		21. Signature of Funeral Service Licer	e Wa	ا كس	2. Name and Add	orth Ave	ARCH FUNI nue Balt:	ERAL HOME imore, MI	E-EAST 21202
8760,	The law requires that the death certificate be executed was been signed by the ettending physician and large 2 should be detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a c.	a consequence of):	jocara	0.0	nfarch	LOY	Approximate Interval Between Onset and Death
P.O. Box 6	that the death certific ed by the ettending p detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnar Other (specify)	ncy		23d. Date Mont	
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of Vital Record		Completed						24a. Was autor perfo 1 □ Yes	osy pri ormed? de	ere autopsy findings available or to completion of cause of ath?
f Vit	S D	To Be	25. Was case reterred to medical examiner?  1  Yes 2 No	Hospital: 1   Inpatier	nt 2 ER/Outpatien	t 3 DOA	at at	eath (Check only of Home 5 Resid	one) dence 6 ☐Other	(Specify)
	9 9 9		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injun (Month, Day	Year) 28b. Time of Injury	W			how injury occurred	
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	To the Hospital of within 24 hours at To the Funeral D completely filled in	Medical	29a. Certifier (Check only one) 1 Certifying Pt 2 Medical Example 1	ysician: To the best o niner: On the basis of and manner stat	examination and/or inv	estigation, in my	opinion, death occ	curred at the time,	date and place, an	d due to the cause(s)
)	To the within 2 To the complet	Σ	29b. Signature and title of dertifier	Trupe	acu	29c. Lice	30 661		29d. Date signed (	Month, Day, Year, 2005
	3		30. Name and address of person who 560/ Loch	completed cause of de	ath (Item 23a) Type,	PrintBall	inor.	rd.	-2123	39
*	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 6 20	32 Registra	r's Signature	wie				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First, Middle, Last) Dav Month Year **Physician** T.ZOPM 2005 Vaoni VYamb RNNIC /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner If Under 24 Hrs. Washi more If Under 1 Year Date of Birth (Month, Day, Year 2/23/1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6 Sax **Funeral** Days Months 1 ☐ M 2 💢 F 93 VA 225-05-8933 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show ir than "natural", or Items 23a or 28a-f show the Medical Examinal handlifed at 1 ☐ Yes 2 No Cedar Bluff Director VA Tazewe11 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 12 River Road 24609 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: Specify. White þ 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Retail Store Manager Ith and Mental Hygis 27 Is marked other I r traumatic event, III 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Bertha Bell Childress Tom Moslev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Important: if Itam 27 is any injury or other traum. Mr. Tom Hawkins - Grandson 7024 Cresthaven Drive, GLen Burnie MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 12/2/2005 Claypool Hill, VA Greenhills Memory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. permit. Departr 21. Sign ture of Funeral Service Licensee 1 Second Ave SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a cons Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Live birth 2 Fetal death Day Year in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? illed in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Director: After Natural 5 Pending 2 🗆 No death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital o within 24 hours af To the Funaral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie address of person who completed cause of death (Item 23a) (Type, Print) V V 32. Registrar's Signature

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 6 2005

app

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Byung Youl Kim Nov. 30 2005 9:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 105 Medlow Ct. Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 15 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√F Director 213-68-1246 71 Yrs. Korea 1935 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "naturel", or Items 23a or 28e-f show the Madical Examiner oust be notified at MD **Baltimore** Timonium 1 □Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Medlow Ct. 21093 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Be Completed by Specify: Korean 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) n/a Food Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ould be f . Pages 1 and 2 should be trient of Health and Menta tent: If item 27 is marked Moon Jib Park Kim Soon Hee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chong Kun Kim/husband 103 Medlow Ct., Timonium, MD 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 12/5/05 20a. Method of Disposition 20c. Location - City or Town, State 1 Magazial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 0 permit. Page Department of Importent: If any injury or once. Meadowridge Memorial Park Elkridge, MD 21. Signature of Funeral Service Licensee Gary L. Kaufman Funeral Home @ Meadowrid je MP, Inc. 7250 Washington Blvd., Elkridge, MD 21075 PM.1. Enter the disease, or complex tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Condiovas cular Disease Physician Artenioscleratic 10 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician for use as the buria Completed by Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown ģ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown peed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy performed? Yes 2 No this certificate 1 Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA To the Hospitel or Attending Physwithin 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D18667 Deput 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Trimble Hill Ct., Lutherville, MD 21093 Philip Militello, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) DEC 0 6 2005 State Registrar

			1 - For State Registrar	State of Maryland			of Health of Death			iene og. No.	05	39286
	Physici	an	1. Decedent's Name (First, Middle, Last)	77 . 7					2. Date of Deat	th Day	Year	3. Time of Death
	/Medic		Frederick Alle						Dec 3,	2005		14:55 P <sup>M</sup>
1	Examin	er	4a. Facility Name (If not institution, give st			_	own, or Location	of Death			nty of Death	
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	Funeral Director			M 00 5	'5 Yrs.		Days Hours	Min.	Jan 7.	Year)	COL	place (State or Foreign Intry) Hampshire
	D		Usuaf Residence of Decedent	,				1	Jali 7,	1930	INCW	nampshire
	how thow		10a. State 10b. County		, Town or Lo							10d. Inside City Limits
	Ba-f	Director	Maryland Prince Ge	eorge's Di	istrict							1 □ Yes 2√√No
	with the	급	10e. Street and Number 2209 Breton D	rive		10f. Zip C			1	Og. Citizen		•
	within 72 hours after death with the Maryland one. Itan "natural" or Itama 23a or 28a-t ahow Ita Madical Examinar must be notified at	Funeral		2. Was Decedent Ever in U.	C 12 1		20747	rigin? (Spec	ify Vac or No		d Sta	
_	r Itan	표	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	l·		ent of Hispanic Or by Cuban, Mexica	in, Puerto R	ican, etc.)		fack, White	
3	el', o	þ	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	Yes 2	No Specify	<i>r</i> :		Spe	cify: Whi	te
9500-61212	72 ho	Completed	15. Decedent's Education (Specify only highest grade	ation completed)	16a. Deced	lent's Usuaf	Occupation done during mos	st of warking	2	16b. Kind of	Business/Ir	ndustry
7	nen.	ig I	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	life. L	DO NOT use	retired)		•	<i>a</i> :	T	. 1
Z	iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)			Sales		orla Alama i	First, Middle, I		ant F	oous
yland	antal h	Be c	George Knight				IS. MOIN	_	ice Kin		ame)	
<u></u>	shoul nd Me mark mati	ပ	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	a Address (	Street and Numb				vn State Zi	p Code) 34269
Mar	nd 2 selfth ar 27 la r treu		Milan Knight(Broth				West Egr					
Baitimore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelin and Manth Hydens.  If the firm 27 is marked other than "natural", or itama 23a or 28a-f show it if than 27 is marked other than "natural", or itama 27 is mortice avant, the Maritsal Examinar must be notified at		20a. Method of Disposition	0/	lace of Dispos metery, cren	sition (Name	e of	Da	te	20c. Locatio	n - City or T	own, State
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	/Medical Examiner			Pue to (or as a consequEIDNEY	uence of):	101	5					
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	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	PULMON,	ARZY	4	PERTE	EN SI	CNO			
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DIVISION	Mttand death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	me farm stre		1 Yes 2		of Location /St	reet and Nu	mher or Que	al Route Number,
2	al or Attanding Physician: T s aftar death. Il Diractor: After this cartificet ad in by the funeral director, p	Certification:	4 Homicide determined	building, etc. (Specify	)	, .a., .	511100		City or Town	, State)	11007 07 7101	ai riodio ivaliabor,
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physi	cian: To the best of my know	wledge, death	occurred at	the time, date ar	nd place, an	d due to the ca	use(s) and	manner as s	stated.
	the H nin 24 the Fi	fedical	0.10)	er: On the basis of examinat and manner stated.	ion and/or inv			ath occurred	at the time, da	ate and plac	e, and due t	o the cause(s)
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	$\mathcal{V}$		30. Name and address of person who con SISOM OSIA, GI	npleted cause of death (Item	23a) (Type, I	Print)	TE ton	(9xn	N HII	MAN	20	Luc
	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar's Signat	We I	made s	,, 0 ,,=0	0/4	/(-	- 10	· ·	( )
	Registr	ar	DEC 0 6 200	15 Brews A	5 /							

			For State Registrar	State of M	aryland		artment of F				jiene 0 0 5	39287
	Physici /Medic	al	Decedent's Name (First, Middle     ELSTE BURKENS     4a. Facility Name (If not institution	TURNER KUZN			4h Cih. Tour	- Loostion		2. Date of Dea Month Dec •	<sup>Day</sup> 200	
	Examin	er	Keswick Multi-				4b. City, Town, o		of Death		4c. County of n/a	
	Funeral Director		5. Social Security Number 218-01-3688		ige (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth April 1	9	Birthplace (State or Foreign Maryland
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation					10d. Inside City Limits
	a-fsh	ctor	Maryland n/a		Ва	altimo	re					1 XYes 2 □ No
	within 72 hours after death with the Maryland ene. than "naturel", or Iteme 23e or 28e-f ehow ta Madigal Ezantiner must be milled at	by Funeral Director	10e. Street and Number	t			10f. Zip Code 21211			1	0g. Citizen of Wha	at Country?
	Jeath Te 234	erai	700 W.40th S	12. Was Deceden	t Ever in U.S.	. 13.	Was Decedent of H	lispanic Ori	gin? (Spec	ify Yes or No-	U.S.A.	American Indian,
ဖွ	or Iter	Fun	1 ☐ Never Married 2 ☐ Marr	Armed Forces	?		If Yes, specify Cuba	an, Mexican	n, Puerto R	ican, etc.)	Black,	White, etc.
003	urel',	d by	3 Widowed 4 □ Divorced	Year or Dates	- WW 1	1	1 ☐ Yes 2X No	Specify:			Specify:	White
21215-0036	n nat	piete	15. Decedent (Specify only highes	it grade completed)	5.)	(Give	dent's Usual Occup kind of work done DO NOT use retired	durina mos	t of working	g	16b. Kind of Busin	ness/Industry
212	giene.	Completed	Elementary/Secondary (0-12)	College (1-4or	75+)	Payro	ll Clerk				Electri	c Co.
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examiner intermet in an Doce.	Be	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle,	Maiden Sumame)	
2	should nd Mer marke	은	Albert Palmer 19a. Informant's Name/Relations			19b Mailir	ng Address (Street	Saral and Number		Route Number		bitz
<u>s</u>	nd 2 saith ar 27 is r trau		Blair W. Donoh		l)		ancery S				-	
Baltimore,	es 1 a of Hea f Item r othe		20a. Method of Disposition 1 XBurial 2 ☐ Cremation		20b. Pla		sition (Name of matory or other place		Da		20c. Location - Cit	
Ē	Pag tment tent: I		4 □Donation 5 □ Other (S)	oecify)	Sac		eart of J					e,Maryland
Baj	Departing Departing Important Import		21. Signature of Funeral Service	Snap			Name and Addre Mitchell- 6500 Yor					d 21212
			23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	confications that cause only one cause on each	ed the death. line.	Do not ent	er the mode of dyin	ig, such as	cardiac or	respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		Stage A		mers Dis	ease_				
≥,	Examiner		Securation like liet and ditions	b	o a conseque	nice ory.						
	sit ad	iner	Sequentially list conditions, if any, leading to intribulate cause. Enter Underlying Cause (Disease or injury		5 a BuriBaqua	mes of):						3
•	xecute and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or a	s a conseque	ence of):			-			-
8760,	cate be executed obysicien and the burial-transit	cai		d.								
9	ntificat ng phy a as th	Pa	IF FEMALE:									
Box	es that the death certific igned by the attending p be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant	2 Fetal d	leath 3□	Ectopic pregnancy Other (specify)				23d. Date o Month	
P.0	at the	Phys	9 🗆 Unknown	9□ Unknown								
	w requires the been signed should be de	by	Part II. Other significant condition	ns contributing to death	but not result	ting in the u	nderlying cause giv	en in Part I.	•			ite to the cause of death?  Probably 4 Unknown
l Records,	The la ete has page 2	Completed								24a. Was a autops perform	ned? prio	re autopsy findings available r to completion of cause of th?  Yes 2 □ No
Vital	Attending Physician: The r death. ector: Atter this certificate ha ector: Atter this certificate haby the funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:			1 04	-	eath	Check on y on		
of	Phys r this ral dir	5. To	1 Yes 2 No	1 ☐ Inpai		R/Outpatier 28b. Time of	ot 3 DOA Oth	4 h_219u			ence 6 Other (	(Specify)
ion	nding ath. r: Afte e fune	atior	1 atural 5 Pendin 2 Accident investig	g (Month, D	ay Year)	Injury	Wor	k? Yes 2 □ I			ow injury occurred	
Division	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could r 4 Homicide determ	ined 286. Place of I	njury - At hom etc. (Specify)	ne, farm, str	eet, factory, office		28	Bf. Location (St City or Town	reet and Number on, State)	or Rural Route Number.
Ω	pital o		29a. Certifier 1 Certifyin	a Dhusiaian. Ta da h								
	• Hos 24 hc • Fun letely	edical	(Check only 2 Medical one)	g Physician: To the bes Examiner: On the basis and manners	of examination	on and/or in	vestigation, in my o	ne, date an pinion, dea	d place, an	d due to the cand at the time, d	ause(s) and manne ate and place, and	er as stated. I due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		- L	11	29c. Licens			2	9d. Date signed (A	Month, Day, Year)
) .	4		Myntelle	Macgree		עי .		3657			Decembe	r 5, 2005
0	`		30. Name and address of person M Isabelle	MacGregor MI	700 V	√ 40th	Street	Baltin	more,	Maryla	nd 21211	
A Company	Sta Registr	_	31. Date filed (Month, Day, Year)  DEC 0	2005 32. Sgis	trar's Signatu	re //	park					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month December 2, 2005 **Physician** Carl Michael LaVerghetta 11 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pikesville Baltimore 420 Milford Mill Road | House 1 Year | House 24 Hrs. | 8. Date of Birth (Month Day) | Days | Hours | Min. (Month Day) | Year) | 1911 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 94 Pennsylvania Director 164-18-6925 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked other then "natural", or Items 23a or 28a-f show traumatic event, the Machical Experience rest to crotified at Pikesville Maryland Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 420 Milford Mill Road united States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No !f Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify:White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Construction Work 12 -0-Utilities Contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Peges 1 and 2 should be fill ment of Heelth and Mental Hient: If item 27 is marked other. Be Rita Muratore Nicholas LaVerghetta ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rita LaVerghetta (Wife 420 Milford Mill Road Pikesville, MD 21208 permit. Peges 1 and Department of Heelt Importent: If item 2: any injury or other i 20b. Place of Disposition (Name of Date 20a, Method of Disposition 20c. Location - City or Town, State Metro Crematory, Inc Dec.7, 2005 Catonsville, Maryland 1 ☐ Burial 2 【Oremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Segrice License 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc Myon Moo333 8728 Liberty Rd. Randallstown, MD 21133-4784 . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failing. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1010 SCLEDSIS **Physician** disease or condition resulting in death) 20 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decase or mary that initiated events Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit attending physicien and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the al 4☐ Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autonsy performed? certificate 1 Yes 2. No or Attending Physicien: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospitel o within 24 hours at To the Funerel D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e D0020964 12/05/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jerome H. Ginsberg, M.D. 1100 Reisterstown Rd., Suite 202, Pikesville, MD 21208 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 6 Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 = For State Registrar	State of Marylan		artment of Health and tificate of Death		ene 005	39289
			1. Decedent's Name (First, Middle, Last)	/ /			2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Bonis a	encho			Dec 2,2	005	9:00A M
	Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or Location of Deat	th	4c. County of Dea	
			3512 Pinevale		da na hiinda ni	Forestville  If Under 1 Year   If Under 24 Hrs	D. D ( Dist.	Prince (	
	Funeral Director		5. Social Security Number 6. Sex 230 14 5548	7. Age (In yrs.	Yrs.	Months Days Hours Min.			thplace (State or Foreign
			Usual Residence of Decedent				NOV 20,	1923   VII	rginia
	how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation			10d. Inside City Limits
	e Ma	cto	Maryland Prince (	George's For	restvil	.le			1 Tes 2 No
	vith th	Director	10e. Street and Number			10f. Zip Code	10	g. Citizen of What Co	ountry?
	s 23s	rai	3512 Pinevale Ave		6 40 1	20747	S	United St	
	Item Item	nu	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No	.5. 13. 1	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	14. Race - Ame Black, Whit	
936	ors af	by	3 XWidowed 4 □ Divorced	If Yes, Give X Year or Dates:		□ Yes 217 No Specity:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow the Medical Examiner must be notified at	Completed by Funeral	15. Decedent's Edu (Specify only highest grade			lent's Usual Occupation kind of work done during most of wo	diag.	6b. Kind of Business	/Industry
21	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired)	g		
	led w tygier her th	င်	12 17. Father's Name (First, Middle, Last)		Leg	al Secretary	me (First, Middle, Ma	Law Firm	
Maryland	t be fi	Be	John W. VeRel	1			WeRell	alden Sumame)	
Ž	hould id Me mark matic	ဥ	19a. Informant's Name/Relationship (Ty		19h Mailin	g Address (Street and Number or R		City or Town State	Zin Code)
<b>∑</b>	nd 2 stith ar		Nikki Saulsbury (I		Charman	Pinevale Ave., F			6003
ře,	of Heal		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place) Dec 7,	Date 2005	ML 217 C. Location - City or	Town, State
Ë	Page nent c int: If		1 Donation 5 Other (Specify)			tion Cemetery	2005	linton, M	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 2006.		21. Signature of Funeral Service License		22	. Name and Address of FacilityLee	Funeral	Home. Inc	6633 Old
	827 2 8		Wil DOGa	h 10015	3	Alexandria Ferry	Road, Cli	nton, MD	20735
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the deatl	h. Do not ente	er the mode of dying, such as cardia	c or respiratory arres	st,	Approximate Interval Between Onset and Death
ı	Physician		Immediate Cause (Final disease or condition resulting in death)	Sudden	Cure	lu Deall			Criser and Death
1	/Medical Examiner		(esulting in dealth)	Due to (or as a conseq	uence of):	0. 12. 4			11 6
	4.0	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):	were on to	ickin		
	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cevon 2	To /3	Their Feleral			
ó	en en rial-tr	Еха	resulting in death) Last	Due to (or as a conseq	ugince of):				
8760,	icate be executed physicien end s the burial-transit	dicai		l					
9	entific ling p	Mec	IF FEMALE:	2- 14					
Вох	that the death certified by the attending detached for use as	Physician/Me	in the past 12 months?	3c. If yes, outcome of pregna  1 ☐ Live birth 2 ☐ Feta  4 ☐ Pregnant at time of d	Ideath 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of de Month	livery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	eatii 5	Other (specify)			
<u>α</u>	that ned b	by Pr	Part II. Other significant conditions con	tributing to death but not res	ulting in the ur	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	quires an signa uld be	ed b					1 🗆 Yes	2 □ No 3 □ Pr	robably XXUnknown
000	The law requires that ste hes been signed b page 2 should be deta	plet					24a. Was an	24b. Were au	utopsy findings available
ĕ		Completed					autopsy performe 1 ☐ Yes 🔏	ed?   death?	completion of cause of
/ita	Physician: Th this certificete ral director, pag	Be	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one,		
) t	Physic this c	ပ္	I I 162 STANO		ER/Outpatien		lome 57 Residen		ocify)
n		lon:	27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
Division of Vital Records,	Attending r death. ector: After by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm str		28f Location (Stre	et and Number or Ri	ural Route Number
<u>S</u>	or effer Direction	Certification;	4 Homicide determined	building, etc. (Specifi		ot, raciory, office	City or Town,		arai riodio i varibor,
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifying Physical Check only 2 Medical Examin	sician: To the best of my kno	wledge, death	occurred at the time, date and place restigation, in my opinion, death occi	e, and due to the cau	se(s) and manner as	s stated.
	thin 2 the I	Medical	29b. Signature and title of certifier	and manner stated.		29c. License number		Date signed (Mont	
	5 7 × 5		and the state of t	0.		1) 6020/	63	12/1/1/	(1
7	$\sigma$ .		30. Name and address of pers who co	mol led cluse of death (from	23a) /Tune	Print)	4-1	1-13/	0 3
	1,	1. 8	Conor Lunc	1	- //	1070 Old Line	(tr#303	Molds	v. C O
				1 4 1 64 CALL 1. 1 1 1 1	U . /e	DIG LINE		1/2/21/11/0	YT MU
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 6 20	32 Pagistrar's Signa		Sand I	COC+ 303	)	30907

Amend item#20b, perfh, G850, 12/6/05 11 | State of Maryland / Department of Health and Mental Hygiege 1 - State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2005 Year DECEMBER 2 **Physician** SUE LEVIN 2:30P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3509 OVERBROOK ROAD BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 214-64-3311 Yrs Director 03/04/1954 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 X No BALTIMORE BALTIMORE Directo 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21208 3509 OVERBROOK ROAD U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: þ WHITE 3 ☐ Widowed 4 M Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other then any injury or other treumstic event. Ins Ma College (1-4or 5+) 5+ Elementary/Secondary (0-12) EDUCATION TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be LEVIN MOLLY R KRUGER SIDNEY 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3509 OVERBROOK ROAD - BALTIMORE, MD 21208 SIDNEY LEVIN / FATHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 11/05/2005 RANDALLSTOWN, MD 21. Signature of Funeral Service License 22. Name and Address of FacilitySOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 John 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of) 3/2 years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the ettending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown cete hes been signed by , page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an After this certificete hes autopsy 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier By MD 29c. Ligense number 310200 5 MADHU CHAUDHRY, GBMC, Priation Cer Cever MADHU CHAUDHRY, GBMC, Baumare Mb 6569 N Charles Street 32. Aegistrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 6 2005

DHMH 17 Rev 1/2001

Registrar

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Laternine M	3. Time of Death
Medical   Examiner   4a. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   4c.	
Funeral Director    S. Social Security Number   S. Sex   T. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   S. Date of Birth (Month, Day, Year, Months Days Hours Min.   20   PH   Usual Residence of Decedent	2005 (2507 M
Funeral Director  5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 Month, Day, Year, 1 Usual Residence of Decedent	. County of Death
Director Usual Residence of Decedent	HARFORD
Usual Residence of Decedent	9. Birthplace (State or Foreign Country)  MALY LAND
10a. State 10b. County 10c. City, Town or Location FOREST HILL	3 MACTERIAL
* if 8 110 HARFORD TOREST HILL	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
£ 0 0 10 0 10 0 10 0 10 0 10 0 10 0 10	
10g. Ci	tizen of What Country?
20 CALDEN DR. 21050  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1   Never Married   2   Married   1   Yes   2   No	14. Race - American Indian,
Armed Forces?  If Yes, specify Cuban, Mexican, Puèrio Rican, etc.)    Married   1   Never Married   2   Married   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   No   1   Yes   2   No   No   Never Married   1   Yes   2   No   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes   2   No   Never Married   1   Yes	Black, White, etc.
If Yes, Give Year or Dates:	Specify: WHITE
Second Specify:    Second Specify:   1   Yes 2   No Specify:   1   Yes 2   No Specify:   1   Yes 2   No Specify:   1   Yes 2   No Specify:   1   Yes 2   No Specify:   1   Yes 2   No Specify:   1   Yes 2   No Specify:   1   Yes 2	(ind of Business/Industry
Elementary/Secondary (0-12) College (1-4or 5+)	OSTRUCTION
77. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maider	Sumame)
FRANCIS A. HERBERI  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street and Number or Rural Route Number, City of Street Route Number or Rural Route Number, City of Street Route Number or Rural Route Numb	· NOETH
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maider, Mai	or Town, State, Zip Code)
200. Place of Disposition (Name of Date 200. L	_, MD Z1050
200. In Section 1   Section 2   Section 3   Removal from State    1   Burial 2   Cremation 3   Removal from State    1   Burial 2   Cremation 3   Removal from State    1   Burial 2   Cremation 5   Other (Specify)    1   Characteristics   Constitution   Constitu	ocation - City or Town, State
20a. Method of Disposition    Date   Communication   Communica	LISTON, IVID
21. Signature of Funeral Service Licensee  22. Name and Address of Facility EVIDAS FUNERAL SERVICES TO	HILLMD 2000
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician disease or condition disease or condition in resulting in death)	Onset and Death
Due to (or as a consequence of):	
Examiner  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	
per per per per per per per per per per	
de production of the productio	
JO O O O O O O O O O O O O O O O O O O	23d. Date of delivery  Month Day Year
in the past 12 Months? 1 Yes 2 D No 9 Unknown  in the past 12 Months? 1 Yes 2 D No 9 Unknown	Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	use contribute to the cause of death?
Part II. Other significant contributing to death but not resulting in the underlying cause given in Part I.  239. Did tobacco to the underlying cause given in Part I.  1   Yes 2	☑No 3 Probably 4 Unknown
Accluded by the state of the st	24b. Were autopsy findings available
The same of the sa	prior to completion of cause of death?  1 \sum Yes 2 \sum No
Performed?  1 Yes 2 No  25. Was case referred to medical examiner?  1 Yes 2 No  26. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence	72100 2210
Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other. 4 Nursing Home 5 Residence	
27. Man fer of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury 3 Accident investigation 4 1 Visual 5 Pending (Month, Day Year) 4 2 Accident investigation 5 Pending (Month, Day Year) 4 1 Yes 2 No	y occurred
1 / Natural 2   Accident 3   Suicide 4   Homicide   Homicide   Street and City or Town, State	nd Number or Rural Route Number,
27. Man fer of Death 1	)
	and manner as stated.
29a. Certifier  Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) of examination and/or investigation, in my opinion, death occurred at the time, date and manner stated.	
	te signed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Box, 55 55 20 C15 20. Mar Phal Belanme	Gember 1, 2005
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
State 31. Date filed (Month, Day, Year) 32. Agistrar's Signature	
State Registrar  DEC 0 6 2005  Registrar  State Registrar	

			1 - For Registrar	State of Marylan		artment of F rtificate of			giene 0 0 5	39293
ý	Physici	ian	1. Decedent's Name (First, Middle, Las	40	₹			2. Date of Dea Month	th Day Year	3. Time of Death
1	/Medio		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	DECEM	4c. County of Dea	
	LXamii	.c. ⊗ _			OS PITA	RA	CTIMERS		1 6	MORE
*	Funeral		5. Social Security Number 6. Se			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Bir	thplace (State or Foreign
No.	Director		Usual Residence of Decedent	5	7 115.			8/23/	1946 M	ARYLAND
	hours after death with the Maryland tural, or Items 23a or 28a-f show al Examinar must be notified at	_	10a. State 10b. County	9	y, Town or Lo					10d. Inside City Limits
	the Ma	Director	mo		SAUTI	MORE				1- Yes 2 No
	with I	iDir	6207 Brock	Aus.		10f. Zip Code	1201.	1	log. Citizen of What Ci	,
	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in U	.S. 13.	Was Decedent of H	Hispanic Origin? (Si an, Mexican, Puert	pecify Yes or No-	14. Race - Ame	erican Indian,
90	ours after death with the Marylan rai', or items 23a or 28a-f show Examinar must be mutified at		1 Never Married 2 Married	Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give 1 € 666.		Yes, specify Cub.	_	o Rican, etc.)	Black, Whi	te, etc.
Ö		ed by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	71	dent's Usual Occur			L	JHITE
215	within 72 ho ene. then "natur he Medical	piet	(Specify only highest grade Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	_ (Give		during most of wor	king	16b. Kind of Business	maustry
21	T S S S S S S S S S S S S S S S S S S S	Completed	12	Ollege (1-401 5+)	roli	CE O	FFICE			FORCEMENT
Maryland 21215-0036	be be	Be	17. Father's Name (First, Middle, Last)	· Mean			1 -	1	Maiden Sumame)	
Z	2 should be and Mental is marked c	٩	19a_Informant's Name/Relationship (7	MEADOL		n Address (Street	LOKNA	· · · · · · · · · · · · · · · · · · ·	City or Town, State,	Zin Code l
	s 1 and 2 should f Health and Mer item 27 is marks other traumatic		GLORIA MEAD	,		7 BROW	^			
ore,	es 1 a of Hex fitem rothe		20a. Method of Disposition  1 Burial 2 Cremation 3	20b. F	lace of Dispo	sition (Name of plantary or other plantary)		Date	20c. Location - City or	70 21206 Town, State
ij	Page Iment o tant: if jury or		4 □Donation 5 □ Other (Specify	)	CHAPE	L-18EC	AIR Co.	2005	FOREST 1	1.11, mD
Baltimore,	permit. Pages 'Department of H important: if ite eny injury or ot		21. Signature of Puneral Service Licen:	see ///		. Name and Addre	ess of Facility	vans F	YNERAC C	CHAPEC
			23a. Pana. Enter the disease, or comp	olications that caused the deat		$800 H_A$	RFORU)		ARKvillE	MD 21239 Approximate
	Physician		Immediate Cause (Final	one čause on each line.		,		,	,	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	a Due to (or as a conseq	uence of):					
	Examiner	<b>L</b>	Sequentially list conditions,	b	-0					
	ted nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq PNEUM						
Ć.	execusin and ial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a conseq			-	-		
8760	The law requires that the death certificate be executed tite hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai		d GEPSIS						
9	entifica ding ph	/Med	IF FEMALE:	02- 14						
Вох	eath certific attending p	clan	in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3 [	Ectopic pregnancy Other (specify)	4		23d. Date of de Month	livery Day Year
Ö.	that the d ed by the detached	Physician/Me	1  Yes 2 No 9 Unknown	9□ Unknown						
S, P	es tha igned be del	by P	Part II. Other significant conditions co						pacco use contribute to	the cause of death?
ord	w require been si should b	Completed	VENTRICULAR	FIBRILLAT	1014	HYPERT	TENSTON	1 Ye	es 2 No 3 Pr	obably 4 Unknown
3ec	hes b	mple	CORONARY A	RTERY DISE	7SE	DIABE	TES,	24a. Was a autops perform	y prior to	itopsy findings available completion of cause of
la		e Co	25. Was case referred to medical	VASCULAR	DISE	ASE		1 ☐ Yes	No 1 ☐ Yes	2 🗆 No
Ž	Physicien: this certificant director,	To B	examiner?	Hospital:	ER/Outpatien	t 3 DOA Oth		th <i>(Ch</i> eck o <i>nly on</i> ome 5 □ Reside	e)_ ence 6 □Other <i>(Spe</i>	cutu)
n o	D 0 0		27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		y at k?	28d. Describe ho	w injury occurred	ony,
sio	r Attending er death. rector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
Division of Vital Records,		Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, tarm, stre	eet, factory, office		City or Town	reet and Number or Ru n, State)	ural Route Number,
_	To the Hospital or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier	ysician: To the best of my kno	wledge, death	occurred at the tir	me, date and place,	and due to the ca	ause(s) and manner as	stated.
	Within 24. To the Fu	Medical	one)	iner: On the basis of examina and manner stated.	tion and/or inv	restigation, in my o	pinion, death occur	red at the time, d	ate and place, and due	to the cause(s)
	To with	2	29b. Signature and title of certifier	Kan M	٨	29c. Licens	e number		9d. Date signed (Mont.	
	- 12	2	30. Name and address of person who of	mon				OF	CEMBER	5 , 2005
16	91/		STUTI SHANKA		(H K	AVEN	BLVD, B	BALTIM	ORE, MP	21239
10	Sta		31. Date filed (Month, Day, Year)	32. Hegistrar's Signa		ade				

		ľ	1 - For State Registrar	State of Maryla		ent of Health and Nate of Death	Mental Hygien	000 00	294
	Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  Unibert  4a. Facility Name (If not institution, give	oseph 1	liller 4b. G	city, Town, or Location of Death	2. Date of Death Month December	V	me of Death
	Examii Funeral Director	iei 	Franklin Square	Hospital (	Center	Rosedale If Under 24 Hrs.	8. Date of Birth (Month, Day, Year	Baltimon  9. Birthplace (S Country)  MARYL	
	death with the Maryland me 23a or 28a-f show rmust be notified at	ector	Usual Residence of Decedent  10a. State  10b. County	10c. C		NORE Zip Code	100.0		de City Limits
	5 Z Z	Funeral Director	10e. Street and Number  2023 + 1	12. Was Decedent Ever in Ameri Forces?	U.S. 13. Was De	acedent of Hispanic Origin? (Si specify Cuban Mexican, Puerti		14. Race - American India Black, White, etc.	an,
	Maryland 21215-0036 d.z. should be filed within 72 hours after the and Mental Hygiene. "Instance", or lite treumatic event, the Madical Examples.	Completed by	3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Dates:	16a. Decedent's l	s 200 No Specify:  Jsual Occupation f work done during most of wor T use retired)	king 16b. i	Specify: White	<i>C</i> .
ilbert	Taryland 2121 2 should be filed within and Mental Hygiene. ie marked other then eumatic event, tha Ma	To Be Com	17. Father's Name (First, Middle, Last)	ller	Traffic +	Iransportation 18. Mother's Nan Soohi	COLOR Maide CECTS	Dalt, Lite stbrich	1 GOV.
٠, )	lore, Mary ges 1 and 2 sho it of Health and 1 if item 27 is mu or other treums		19a. Informant's ame/Relationship (Ty  20a. Method of Disposition  10k Burial 2   Cremation 3   F	urdel-nepher	19b. Mailing Add	(Street and Number or Ru Name of or other place)	BALTINOS	- 24 0	236
	Baltimore permit. Pages 1 a Department of He important: if item eny injury or oth		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	aunticu	PEACE	COMCHUY 121' e and Address of Ficility 3 FUL ALTEKNATI	VESTUNER	TOMORIUM M PAC+CREMA	MUD DZIO93 TIONCEN
2	Physician /Medical		23a. Part 1. Enter the disease of compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	idati ns that caused the de- n cluse of each line. Due to (or as a conse	atitis	mode of dying, such as cardiac	or respiratory arrest,	Interva	ximate al Between and Death
	3760, ate be executed expected mysicien and me burial-transit	ical Examiner	if any, lauding to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a consect.  Due to or as a consect.					
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the ettending physicien and completely filled in by the tuneral director: page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3 □Ectop	ic pregnancy r (specify)		23d. Date of delivery Month Day	Year
	cords, P.O.  requires that the de been signed by the	þ	Part II. Other significant conditions co	Mellitus		ng cause given in Part I.		use contribute to the caus	
	Division of Vital Records, i or Attending Physicien: The law requires that death.  Director: After this certificate has been signed in by the funeral director, page 2 should be come.	e Completed	Hypertens 25. Was case referred to medical	ion		26 Place of Dec	24a. Was an autopsy performed?  1 Yes 2 N	24b. Were autopsy fine prior to completio death?  1 Yes 2 No	n of cause of
	Vita	0 8	examiner?	Hospital: 1 Inpatient 2	ER/Outpatient 3	Other	ome 5 Residence	6 COther (Specify)	
	Of Phys or this oral di	1: To	27. Manger of Death	28a. Oate of Injury	28b. Time of	28c. Injury at Work?	28d. Describe how in		
	Vision of ratending Phyer death.	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)  28e. Place of Injury - Albuilding, etc. (Spe	home, farm, street, fa	1 ☐ Yes 2 ☐ No	28f. Location (Street a	and Number or Rural Route te)	Number,
	Divisio  To the Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the to	ledical Cer	29a. Certifier Check only 2 Medical Examone)	sician: To the best of my k	nowledge, death occu	rred at the time, date and place ation, in my opinion, death occu	, and due to the cause(	s) and manner as stated.	uuse(s)
	To the within To the compl	Me	29b. Signature and title of certifier	EC-14:4		29c. License number 0 0 0 6 1 257	29d. D	ate signed (Month, Day, You	w/W
	5 S Regis	tate	30. Name and address of person who co	ompleted cause of death (It	00 Frank	lin Square	Drive, Bal-	limore, MD.	21237

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	Division

		Please Type or Print in Black State of Maryland / De	anorthment of Ligalth and N	fental Hygie	2005	39295					
Physicia /Medic	113	1 - For State of Maryland / De Registramen iTFM #17 per fh g850 12/  Nemon McNeill, Sr.	Certificate of Death 06/05 jh	2. Date of Death Month	No.	3. Time of Death					
Examin	er	4a. Facility Name (If not institution, give street and number)  Sinal Hospital of Bautimer  5. Social Security Number  6. Sex  7. Age (In yrs. last birth	4b. City, Town, or Location of Death  Baltimore City  (day) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	4c. County of Death N/A	place (State or Foreign					
Director		241-40-6842	rs.	Dec. 25	1927 1	Carolina  10d. Inside City Limits					
ith the Mary or 28a-f sh	Funeral Director	10e. Street and Number	10f. Zip Code 21215	100	g. Citizen of What Cou USA	Y Yes 2 No untry?					
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Pyglene. Important: if Item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	þ	3841 Boarman Avenue  11. Marital Status  1 □ Never Married 2 □ Married  3 □ ₩idowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ② No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Black Specify: Lac	etc					
ad within 72 hourgiene. er then "nature, in the Manicel E.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  6th grade Lak	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired) OOTET	ang	sb. Kind of Business/l						
hould be file d Mental Hy marked oth matic event	To Be	17. Father's Name (First, Middle, Last)  Hector  Hecto McNeill  19a. Informant's Name/Relationship (Type, Print)  19b. P	Geneva	e (First, Middle, Ma McBride	:						
s 1 and 2 sl f Health and item 27 is r		Margurite Shannon McNeill 3841 Boarman Avenue Baltimore, Maryland  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  12/1/05  20c. Location - City or Town, State									
permit. Pages Department of Important: if i any injury or anse		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of the grad Service Licenside	mount Cemetery  22. Name and Address of Facility Ch. 5240 Reistersto	atman-Ha	arris Fur	Maryland neral Home Md 21215					
Physician /Medical Examiner	al Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do no shop, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of Cause (or	Heart Discase	or respiratory arres	t,	Approximate Interval Between Onset and Death Oou					
o the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death, or the Law requires that death, or the Funeral Director: After this certificate has been signed by the ettending physompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delin	very Day Year					
quires that I in signed by uld be deta	by	Part II. Other significant conditions contributing to death but not resulting in the state of th	the underlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?					
:: The law requir cate has been s' r, page 2 should	Completed	Alcoholism Malnourishment		24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of					
To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	ertification: To Be	2 Accident investigation	patient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residen 28d. Describe how	ce 6 ☐Other (Spec	ify)					
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	O	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)  29a. Certifier 1 Cartifying Physician: To the best of my knowledge.		City or Town,							
To the Hos within 24 ht To the Fun completely in	Medical	29a. Certifier (Check only one)  1 Cartifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.  29b. Signature and title of certifier	29c. License number	red at the time, date	e and place, and due	to the cause(s)					
2		30. Name and address of person who completed cause of death (Item 23a) (T Francis C Donnelly Do	HOO62850 Sina Hospital of	Rel til	most c						
Sta Registr		31. Date filed (Month, Day, Year) DEC 0 6 2005	w	(JAC)							

State of Maryland / Department of Health and Mental Hygien [] [] 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 26, 2005 **Physician** James William Mannion, Jr. 5:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7613 Cayuga Ave Bethesda Montgomery 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 27, 1 Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1**∑**M 2□F 578-12-7145 1916 Director Virginia Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits r than "natural, or items 23a or 28a-1 shovite Medical Exercipes must be notified at 1 Yes 2 No Directo Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 United States 7613 Cayuga Ave. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 □ No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ρ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Chemical Engineer ss 1 and 2 should be filed wood Health and Mental Hygier Iftem 27 is marked other the U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James William Mannion, Sr. Lillian Klein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1513 Warfield Road Edgewater, Maryland 21037 Katherine M. Maginnis / Sister at. Pages 1 e. Jepsefment of Heelit Important: if the enty Injury or once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 11/28/2005 Baltimore Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) John M. Taylor Funeral Home, Inc 22. Name and Address of Facility 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocurd Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine nding physicien and use as the burial-trensit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical ed by the ettending detached for use at 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Sec autopsy performed 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 2 ER/Outpatient 3□ DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury all Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending efter death. Director: Af 1 TYes 2 No investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funaral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sacks, 3301 New Mexico Ave., N.W. Suite 350 Washington, D.C. 20016 Thomas L. M.D. 31. Date filed (Month, Day, Year) 32. Registrar Signature State Sacra DEC 0 6 Registrar 2005

	1	For S'	tate of Maryla		artment of H rtificate of L			giene)	5	39297
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea		Year	3. Time of Death
Physici /Media		Etta Josephine Mille	er				Novews		2115	
Examir		4a. Facility Name (If not institution, give stree	1 -0 16	10-	4b. City, Town, or	Location of Death			y of Death	11
	A .		ton Medic	c. Cene s. last birthday)	n Gen	Sup ne If Under 24 Hrs.	8. Date of Birtl	Anne		pplace (State or Foreign
Funeral Director		5. Social Security Number 6. Sex 1 1 M		Yrs.	Months Days	Hours Min.	(Month, Da) 3-10-1	v, Year)	Cou	intry)
		Usual Residence of Decedent								
ryland how		10a. State 10b. County	10c.	City, Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2425No
e Ma 3a-1 s	cto	MD Anne Arundo	≥1 M:	illersv:						
or 2	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	untry?
e 23s	ra	8317 Sycamore Road	Was Decedent Ever in	118 13	21108 Was Decedent of Hi			U.S.A.	ice - Amer	ican Indian,
ter de Item	in in	The first of the control of the cont	Armed Forces?	0.0.	If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	818	ack, White,	o, etc.
urs af	þ		If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Speci	ify: Whi	te
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led will ygien her th		17. Father's Name (First, Middle, Last)		Home	emaker	18. Mother's Nam	e (First Middle	Own I		
Viano Juid be file Mental Hy arked oth	Be	Benjamin Rush				Cora Pot		maidon dama		
hould d Mei mark matic	ို	19a. Informant's Name/Relationship (Type,	Print)	19b. Maili	ng Address (Street a			er, City or Town	n, State, Zi	ip Code)
Mand 2 st tth and 27 is r		Terry Bland / Daugh			Sycamore					
BBILIMOTE, Maryiatta ZIZISJOOO permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23s or 28s-1 show any Injury or other traumatic event, the Medical Examinar must be nuitling at once.		20a. Method of Disposition	201		osition (Name of matory or other place		Date	20c. Location		
<b>SAILTIMOR</b> Dermit. Pages Department of important: If it is any injury or o		1  Burial 2  Cremation 3  Remote A Donation 5  Other (Specify)	oval from State		lge Memor:	1	3-2005	E1krid	le. I	MD
mit. partm ports ports y Inju		21. Signature of Funeral Service Licensee		2:	2. Name and Addres	ss of Facility	Singleto	n Funer	cal H	ome, P.A.
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/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):						
	la la	Sequentially list conditions, b.	Due to (or as a cons	equence of):					$\rightarrow$	
uted s insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·							
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death certific death certific attending ped for use as for the second se	lan/	23b. Was decedent pregnant in the past 12 mgnths?	If yes, outcome of pre 1□Live birth 2□F	etal death 3	Ectopic pregnancy	1			ate of delivifonth	very Day Year
. 0 00	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	of death 5	Other (specify)					
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Records, P he law requires that has been signed l ge 2 should be det	d by						101	Yes 2□No	3 ☐ Pro	obably 4 Unknown
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Division of the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funeral		29a. Certifier 1 Certifying Physici	an: To the best of my	knowledge, dea	th occurred at the tir	me, date and place	, and due to the	cause(s) and r	nanner as	stated.
ne Ho. ne Fur detely	edical	(Check only 2 Medical Examiner one)	On the basis of exam and manner stated.	nnation and/or in	nvestigation, in my o	ppinion, death occu	rred at the time,	date and place	, and due	to the cause(s)
To the To the Comp	ž	29b. Signature and title of certifier	11) (1)	70 1	29c. Licens	e number		29d. Date sign	ied (Month	h. Day, Year)
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15		29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who compared to the compared to the certifier of the cer	eleted cause of death	tem 23a) (Type	Print)	al Drive	Glen	Burn	¿ M	D, 21061
The state of the s	tate	31. Date filed (Month, Day, Year)	32 Registrar's Si	gnature A	- Way		1	- 0/4 // //		
Regis		DEC 0 6 2005	Jak Jakes	15 1	B. C. Ward					

		For 1 State	State of Maryland	Departi		and Me	ental Hygie	005	39298
		Registrar  1. Decedent's Name (First, Middle, Last)		Certif	cate of Deatr			J. No.	
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Examine	er	Baltimore Washingt		40	. City, Town, or Location ${\sf Glen}\;\;{\sf Burnie}$			4c. County of Death	
- Carronal		5. Social Security Number 6. Sex		birthday) If			3. Date of Birth	Anne Arı	indel place (State or Foreign
Funeral Director		,	M 2□F 79		onths Days Hours	Min. 1	1-29-192	(ear) Cou	place (State or Foreign intry) MD
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death with the Maryland me 23e or 28e-f show ritional ke notified at	Funeral Director	10e. Street and Number		1	Of. Zip Code		10g	. Citizen of What Cou	intry?
23a	rai	129 Faywood Ct.,	Apt E		21060			USA	
ar de	nne		<ol><li>Was Decedent Ever in U.S. Armed Forces?</li></ol>	13. Was	Decedent of Hispanic O s, specify Cuban, Mexica	rigin? (Speci in, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
OO36 hours after tural; or its	<b>by</b> F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 XYes 2 No If Yes, Give Year or Dates:	10	res 2∑ No Specify	<i>y</i> :		Specify:	√hite
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Ilar Menta	To E	Newton McKenny				Kaı	colyn Ma	ydwe11	
C case		19a. Informant's Name/Relationship (Type	pe, Print) 1	9b. Mailing A	dress (Street and Numb	oer or Rural I	Route Number, C	city or Town, State, Zi	o Code)
re, Mai re, Mai s 1 and 2 si t Health and them 27 is r		Mrs. Mary Wagner/g			wood Ct. Ap	t E, (	Glen Bur	nie MD 210	60
Baltimore, semil. Pages 1 a. Department of Hes mportant: if them not holy to cothe ance.		20a. Method of Disposition 1 ☐ Burial 2 🕅 Cremation 3 ☐ Re	20b. Place	of Disposition of Dis	(Name of ry or other place)	Dai	te 20	c. Location - City or T	own, State
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alt		21. Signature of Funeral Service License			me and Address of Facil	ity Sine	leton F	uneral Hom	ρ Ρ Δ
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		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	eations that caused the death. De cause on each line.	o not enter th	e mode of dying, such as	s cardiac or i	espiratory arrest	,	Approximate Interval Between
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X 6	Physician/Med	IF FEMALE:	3c. If yes, outcome of pregnancy						
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m: Tanifficat	ပို	25. Was case referred to medical			00.51	- (D - # )	1 Yes 2	No 1 ☐ Yes	2 No
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g Phy er thi		27. Manner of Death	28a. Date of Injury 28b	. Time of	28c. Injury at Work?		d. Describe how		у)
VISION Attending or death. ector: After	atio	Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		]No			
Division of Vital Records, P.O. Box of or Attending Physicien: The law requires that the death cert after death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street,	actory, office	28	Location (Stree	et and Number or Run	al Route Number,
Di saffe el Dire	Cer		building, etc. (Specify)				City or Town, S	state)	
Hospi 14 hou Funer tely fill	edicai	29a. Certifier 11 Certifying Phys (Check only one)	ician: To the best of my knowled er: On the basis of examination and manner stated.	lge, death occ and/or investi	urred at the time, date ar ration, in my opinion, dea	nd place, and ath occurred	due to the caus at the time, date	e(s) and manner as s and place, and due t	tated. o the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	and marifier stated.		29c. License number		29d	Date signed (Month,	Day, Year)
F 5 F 8		) Act	AZ A B.		Amag.	7.7	Α.		N N 0/"
		30 Name and a ldress of person who con	moleted cause of death (from 22)	) (Type Dries	15439	/ /	シ	- W	2 April S
l v		Lindren Westernin.	201 Hready	Dank	Colon Bru	mi	· ma	2000	)
State	e i	11. Date filed (Month, Day, Year)	32. Registra's Signature	handle	9	, ,	7 7 7 7	-00	/ 1
Registra	ır	DEC 0 6 1005	Jan 183 A						

State of Maryland / Department of Health and Mental Hygienen

DHMH 17 Rev 1/2001

State Registrar

**ORIGINAL** 

7601 Osler Drive, Towson, Maryland 21204

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Eppler, M.D,

DEC 0 6 2005

John 31. Date filed (Month, Day, Year)

		1 - For State Registrar			nent of Health and cate of Death	Re	Z U U J g. No.	39300
Physic /Med Exami	ical	1. Decedent's Name (First, Middle, La FRED Do  4a. Facility Name (If not institution, gi	UGLAS		City, Town, or Location of Dea	2:1	Day Year O S 4c. County of Dec	5 1430 M
Funeral Director			DE MARYLAND 10. Sex 1. Age (In yrs. 1. 43	last birthday) If U	HCT Ball of Under 24 Hr Inder 1 Year If Under 24 Hr Inder 1 Year If Under 24 Hr Inder 1 Year Index Ind	. (Month, Day,	9. Bi 24,1962 M	rthplace (State or Foreign
death with the Maryland me 23s or 28s-f show Traint be rediffed at	ector	10a. State 10b. County  MARYLAND V/A  10e. Street and Number	1	ty, Town or Location		10	g. Citizen of What C	10d. Inside City Limits 1 ✓ Yes 2 □ No
	Funeral Directo		12. Was Decedent Ever in U	20AD 6	21239 Decedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Am Black, Wh	erican Indian,
2-UUSO 72 hours after natural; or its	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 Mo If Yes, Give Year or Dates:	1 ☐ Y	es 2 No Specify:		Specify: 6b. Kind of Business	LACK
filed within 7 Hygiene. other than "rent, the Med	e Completed	(Specify only highest gr Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Las	College (1-4or 5+) YEAR COLLEGE	<b>—</b> .	of work done during most of wo DT use retired)  CTRICIAL  18. Mother's Na			MOYED
ryiarr	To Be	MAUSIOU  19a. Informant's Name/Relationship		IELSON	1 FLORA	LEE	LINK	
TE, INGLYIC s 1 and 2 should f Health and Mer item 27 ie marke other traumatic	1	DARLINE NELSON	I-GRADY GISTER	1439 57		BALTIMO	City or Town, State, RE, MARY	LAND 21239
Page Page nent o ant: if ury or		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control o	Removal from State		or other place) NORIAL PARK 12-		Oc. Location - City o	
Dermit. Departr Imports any inji		21. Signature of Funeral Service Lice	N. Willian	N) 3051	e and Address of Facility  PH H. BROW  N. FULTON A	WE BALT	UNERAL IMORE, M.	HOME Dell17
Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	h. Do not enter the	mode of dying, such as cardia	ic or respiratory arres	st,	Approximate Interval Between Onset and Death
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Physicia this certi	To Be	examiner?	Hospital: 1 Minpatient 2□	ER/Outpatient 3	Other	ath (Check only one) Home 5 Residen	ce 6 □Other (Spe	ocify)
tending P death. tor: After t	ertification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	
A C C S	O	3 Suicide 6 Could not be determined	building, etc. (Specify	r) 		City or Town,		
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	edical	29a. Certifier (Chack only one)  1 Certifying Pl 2 Medical Exam	nysician: To the best of my kno- miner. On the basis of examinal and manner stated.	wledge, death occur tion and/or investiga	rred at the time, date and plac- tion, in my opinion, death occ-	e, and due to the cau urred at the time, date	se(s) and manner as and place, and due	s stated. e to the cause(s)
To t To t	Z	29b. Signature and title of certifier	completed cause of dealing literal to the state of the st	42	29c. License number D00 61862	290	Date signed (Mont	
5		30. Name and a kine of person who	completed cause of death (Item USTMHW: While	23a) (Type Print)	f Manyland			
Sta Registi	-	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture				

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** NECKER 10:40A M 05 BARAH /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VILLAGE IARFORI SPRING H KOCK FOREST 1 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6 Sex 5 Social Security Number **Funeral** Days Hours 1 □ M 2 🛣 F 1919 86 Kansas 212-22-3538 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ii. Pages 1 and 2 should be filed within 72 hours after death with the Marylan riment of Heath and Mentai Hygiene. A retart; if item 23s or 28s-f show ritant; if item 27s marked other than "natural", or litems 23s or 28s-f show injury or other traumatic event, ite Medical Examinatment cannot be redified as 1 Yes 2 No Director Forest Hill Maryland Harford 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 2304 Rock Spring Road 21050 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Marned 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Postal Delivery U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ella Mindwell Rev. Joseph Edmund Thompson, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3913 Pinedale Drive, Baltimore, Maryland 21236 David T. Necker - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □ Donation 5 □ Other (Specify) Christ Episcopal Ch. Cem 12/07/05 Forest Hill, Maryland 22. Name and Address of Facility permit.
Deportrimental Importa 21. Signature/of/Funeral, Service Licensee McComas Funeral Home, P.A. Uffler U/ Hee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Ent. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cluse on each line. Immediate Cause (Final disease or condition Metostatic Physician resulting in death) /Medical Due to (or as a consequence of): Examiner 4FC THO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit C. Due to (or as a consequence of): sician a P.O. Box 68760 Completed by Physician/Medical phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year jo 5 Other (specify) 4□Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page performe 2 3 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA his funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After Division Hospitel or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident the Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Spring Rost, Forest Hail MD 21050 2005 Frederick Walken W 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 6 2005 138 E - 5 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 39302 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Yee 12:028M **Physician** Ohn CAMBE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b: City, Town, or Location of Death Examiner andullstown Bultimere 10spital If Under 24 Hrs. Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 5. Social Security Number **X** M 2□F **Funeral** Days Hours Months 185-18-2856 May 25 1924 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. Count ral, or itams 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland **Baltimore** Woodlawn 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2213 Maple Hill Court 21207 United States of America death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

Large 2 Do No Large 3 Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 🛣 No Specify: Specify: White þ 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) Social Security al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Computer Operators Administration 11 18. Mother's Name (First, Middle, Maiden Sumame) permit. Peges 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked otherny injury or other traumatic svent 17. Father's Name (First, Middle, Last) Thomas Andrew Olear Mary Bartos 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Helen Olear (Spouse) 2213 Maple Hill Court. Woodlawn, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Woodlawn Cemetery 12/05/05 Woodlawn, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Licensee 8728 Liberty Road, Randallstown, Maryland 21133 nel 1100333 Enter the disease, or complications that caused the death. or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immedia Cause (Final disease or condition resulting in death) Atheroscle **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ page 2 should be 1 Yes 2 No 3 Probably 4 Onknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 Yes 2 No 2 No 1 ☐ Yes or Attanding Physician: director. 26. Place of Death | Check only one 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 Yes 2 No 3□ DOA Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28b. Time of After Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death. To the Funeral Director: the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide pellil the Hospital f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0056266 no completed cause of death (Item 23a) (Type, Print) andulation 14 2/133 wolfine Stilous 5701 32 Registrar's Signature 31. Date filed (Month, Day, Year) State DECO 6 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene 15 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2100 Polly Stahl Patzer O /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Agnes N/AHospital 8. Date of Birth Month, Pay, Year) May 11, 1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 X F Ôhio 285-24-5426 79 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "naturel; or items 23a or 28e-f ehow employery or other traumatic event, the Madical Examinan qual be notified at once. 10a State 10b. County 1 ☐ Yes 2 X No Director Catonsville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 100 Oak Drive USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify 3 Widowed 4 □ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Stahl Tom Dana Marguerite Luebcke 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4615 NW 21st Terrace Gainesville, Florida Susan E. Myers, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Metro Crematory, Inc. 12/02/05 Baltimore, MD 21. Signature of Funeral Service Licensee George MacNabb <sup>22</sup> Cremation Society of Maryland, Seon E. Man Mill 299 Frederick Road Baltimore, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cancer Immediate Cause (Final disease or condition resulting in death) Unknows **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Qualto for as a consequence of: Completed by Physician/Medical Examiner burial-transit resulting in death) Last Due to (or as a consequence of): use as the phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 ☐ Fetal death 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ned by the 6 1 ☐ Yes 2 ☑ No P.0. 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Edema 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Unpatient 2 ER/Outpatient 3 DOA ō this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; Division To the Hospitel or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after deatl To the Funerel Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature D0063025 M.D. 7 4312 Old Court Rd, Apt 2A, Pikesville MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cheema 32. Registra's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 05 39304 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death lonth Physician /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Home Year If Under 24 Hrs. are (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 7. Age 8. Date of Birth (Month, Day, Year) **Funeral** 215-03-860 Days Months Hours Min 1 M 2 F ica **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State rel', or Items 23e or 28a-f show Evan iner must be notified at MD 1 XYes 2 □ No Director BALDMOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "naturel", or Item any injury or other treumatic event, the Medical Eventient ODE. Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homo 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be idal UNKNOWN 30050 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 19a. Informant's Na e/Relationship (Type, Print) Mieco Timonium MO annie 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition 1 Burial 2 Gremation 3 Removal from State 12/6 105 Forest 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Andress of Facility YORK RD, Timonium MD 21093 21. Signatur If Funeral Service Acensee Mimbelle PEACEFUL ALTGIONATIVES FUISEPAL + CREMATION CENTER TOTAL 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Dementra Physician tamere disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): and Division of Vital Records, P.O. Box 68760. the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Isigned by the 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 🗆 No 3 Probably 4 ☐ Onknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 24b certificate has autopsy 1 Yes 2 No Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 7 1 🗌 Yes 2 🗆 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: after death. Director: After Hospital or Attending 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗆 No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide within 24 hours a To the Funerel E 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 31464 07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST Inite 308 821 N. FUTAN m1) 2/201 am Intich H 32 Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

			1 - For State Registrar	State of M	laryland		artment of H rtificate of I		Mental Hy	ygief)k Reg. No	. 0 0 0	-	39305
	Physici	212	1. Decedent's Name (First, Middle,	Last)					2. Date of D Month			21	3. Time of Death
	/Medic		RUDOLPH			PECK	00		DECEM	BER		05	0925 AM
	Examin	er	4a. Facility Name (If not institution,		, , , , , , , , , , , , , , , , , , , ,				40	c. County of E	Death		
			5. Social Security Number	Sex 7. Ac		ast birthday)		PALSTON P			3ALT		
	Funeral Director		214-04-5257	1 <b>⊠</b> M 2□F	75 Yrs. Months Days Hours Min.			(Month, D	ay, Year)	"	Count	-	
	ס		Usual Residence of Decedent						12	21	29 .	Jam	aica
	show	-	10a. State 10b. County		10c. City	, Town or Lo	cation					10	d. Inside City Limits
	he M	Director	MD Balti 10e. Street and Number	more	R	andal	llstown						1 Tyes 2 No
	with with						10f. Zip Code			10g. Cit	itizen of What	t Count	ry?
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Maryland 21215-0036	hours ural',		3 Widowed 4 Divorced	Year or Dates:							Specify:		dian
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פַ	e filed Il Hygie other	BeC	17. Father's Name (First, Middle, La				, 42 20.11	18. Mother's Nam	ie (First, Middle			/GT	Inery
/lar		TOE	William Pecko	0				Zella F	indla	v			
lan	- co -		19a. Informant's Name/Relationshi	(Type, Print)		19b. Mailir	g Address (Street a				or Town, Stat	e, Zip (	Code)
	l and lealth im 27 her tr		Dave Peckoo-S	on	OOL DI	281 3	enny Dr sition (Name of natory or other place	ive, We	stmin	ster	. Md	21	158
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3		200. Pla	metery, cren	natory or other place	θ)	Date	20c. L	ocation - City	or Tow	n, State
<u>=</u>	it. Pa		*4 ADonation 5 ☐ Other (Special Service Li		f Kı		morial		2/7/05	Ran	idalls	sto	wn, Md
Ba	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 li any injury or other tre		A Cu	B X.	te	Ma	Name and Address	West	- 1.				
ļ.			23a. Part1. Enter the disease, or conshide, or heart failure. List or	omplications that cause	d the death.	. Do not ente	300 Waba er the mode of dying	SN AVE, g, such as cardiac	or respiratory a	LMOY arrest,	e, Mo		21215 Approximate
5	Pnysician :		Immediate Cause (Final	2 3				granes con .	Unannessee.			(	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	aDue to (or as	a constitu	ence of):	- with	hypoxic	respin	Htg	falu	14	dauge
H	Examiner		Sequentially list conditions	b. ren	1 4	celur	L.				Sr.		days
7	p tis	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a cons qui	ence of):							
V	and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	3 00000000	ence of):							
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68/	tificate be executed g physician and as the burial-transit	edlcal		d									
Box	eath certificate be executed attending physician and for use as the burial-transit	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			le .			- 1	23d. Date of	deliver	,
	The law requires that the death cer te has been signed by the attendir age 2 should be detached for use	Physician/N	in the past 12 months? 1 \( \subseteq \text{Yes}  2 \subseteq \text{No} \)	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnancy Other (specify)				Month		Day Year
д О	res that the de signed by the a be detached t	Phy	9 Unknown							4			
	res the signer	by	Part II. Other significant condition	s contributing to death b	out not resul	ting in the ur	iderlying cause give	in in Part I.	11				cause of death?
Ö	v require been sig should t	eted							10	Yes 21		Probat	oly 4 Onknown
Records,	The law cate has I page 2 s	Completed							24a. Was	an psy ormed?	24b. Were prior t death	to comp	sy findings available pletion of cause of
Vital	10	e Co	25. Was case referred to medical		<u> </u>				1 Tes	2 XNo			DENO.
	Physiclen: this certific ral director,	o Be	examiner?	Hospital:	201	R/Outpatien	t 3□ DOA Othe	26. Place of Deat			- Tau - 12		
ō		L:U	27. Manner of Death	28a. Date of Inju	IV 2	28b. Time of	28c. Injury	at at	28d. Describe			pecity)	
0	uttending I death, ctor: After y the funer	atlo	1 Natural 5 Pending 2 Accident investigat	ion	y rear)	Injury	Work M 1 □ Y	es 2□No					
DIVISION	l or Attend after death Director: , I in by the f	Certification:	3 Suicide 6 Could no 4 Homicide determine		ury - At hon c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location ( City or To	Street an	d Number or	Rural F	Route Number,
	itel o												b
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funerel.	Medical	29a. Certifier  (Check only one)  Certifying  2 Medical Ex	Physicien: To the best aminer: On the basis o and manner sta	t examinatio	eledge, death on and/or inv	occurred at the time estigation, in my op	e, date and place, inion, death occuri	and due to the red at the time,	cause(s) date and	and manner d place, and d	as stat lue to th	ed. ne cause(s)
	To th To th comp	W	29b. Signature and title of certifier				29c. License	number		29d. Dat	te signed (Mo	onth, Da	ıy, Year)
			Donation	- mo.			Do	059736		a	Unper	2	2005
	3		30. Name and address of person wh	o completed cause of d	leath (Item 2	23a) (Type, F	Print)						
	Sta	6	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	Ire THY	VEST HI	DSPITAL	5401	OLP	COURT	R	0.410
	Registr		DEC 0	32. Registr 6 2005	Car.	M.	Coules						

State of Maryland / Department of Health and Mental Hygiene For State Registramend Item #7 Per FH G850 12/19/19/19/19 Reg. No. U 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Month Day Physician Robert S. Permison 9:46 AM DECEMBER 3, 2005 /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 15,1947 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** Months Days 1 ☑ M 2 🗆 F Hours 219-48-2594 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or iteme 23a or 28a-f show the Medical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes XX No Maryland **Baltimore** Directo Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21 Goucher Woods Court 21286 USA Funeral be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting 12 4 n and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Fred Permison Florence Gittelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Depertment of Health a Important: If Item 27 is any Injury or other trai Gail Permison Wife 21 Goucher Woods Court Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 12/5/2005 Catonsville, Maryland Metro Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211

3631 Falls Road, Baltimore, Maryland Approximate

Approximate

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOGENIC SHOCK /Medical Due to (or as a consequence of) Examiner ACUTE ANTERIOR MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit taw requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, PULMONARY EDEMA Completed 1 Yes 24 No 3 Probably 4 Unknown been END STAGE RENAL DISEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 1 ☐ Yes 2. No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: Director: After this certific in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 70 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔯 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check only one) the e within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 29c. License number un 24034 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOW, J. M. D. 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 TIMOTHY 31. Date filed (Month, Day, Year) 32. Registrar's Signature State parte DEC 0 6 2005 Registra

DHMH 17 Rev 1/2001

		1	For State Registrar	State of Maryland / De	Certificate of Death		leg. No.	39307
			1. Decedent's Name (First, Middle, Las			2. Date of Dea		3. Time of Death
	Physici /Medio		Beatrice	Purcel:	1	Nov 30,	2005 Year	6:40 P M
,	Examir		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of E	Death	4c. County of Death	
			6707 Northam R	oad	Temple Hills		Prince (	George's
	Funeral		Social Security Number     6. Security Number		Months Days Hours	Hrs. 8. Date of Birt. (Month, Day	9. Birth	place (State or Foreign ntry)
	Director			<sup>™</sup> 2√F 95 Yr		Oct 25	, 1910 Fall	River, Ma
and	*		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location			10d. Inside City Limits
Aar	n a a	5	Maryland Prince C		77 • 7 7			1 ☐ Yes 🏋 🕅 No
the state of	288	Director	Maryland   Prince G	eorge s   lemple	Hills 10f. Zip Code		10g. Citizen of What Cou	
With	0 3	٥	6707 N1	D 1			United Stat	
eeth	2 2	era	6707 Northa		20748 13. Was Decedent of Hispanic Origin	? (Specify Yes or No-		
<b>.0036</b> hours after deeth with the Maryland	- 4	Funerai	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ Mo	If Yes, specify Cuban, Mexican, F	Puerto Rican, etc.)	Black, White	etc.
036	0,1		₩Widowed 4 Divorced	If Yes, Give TAA Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
5-0 22 Po	Cal	Completed by	15. Decedent's Ed		ecedent's Usual Occupation Give kind of work done during most of	function	16b. Kind of Business/Ir	
21215-0036 of within 72 hours af		g	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	fe. DO NOT use retired)	WORKING		
2	giane.	5		Acc	ountant		Entertainme	nt
Maryland 2	_ 5	Be (	17. Father's Name (First, Middle, Last)			Name (First, Middle,	Maiden Sumame)	
aryla should b	marked matic e	ဥ	Thomas A. Wilk	inson	Berth	na Holden		
and short			19a. Informant's Name/Relationship (7		lailing Address (Street and Number of	or Rural Route Numbe	r, City or Town, State, Zi	Code)
	Health tem 27 other tr		Verna Keese (dau	ghter) 67	07 Northan Road,	Temple HII	ls. MD 207	48
ore	i of H		20a. Method of Disposition  1 Description   3		isposition (Name of crematory or other place)	Date	20c. Location - City or T	own, State
imor	ment ant:		4 □ Donation 5 □ Other (Specify		Hill Cemetery		Suitland, M	
Baltimore,	Department of Important: If i eny injury or one		21. Signature of Funeral Service Licen	/	22. Name and Address of Facility	ee Funeral	Home, Inc.	6633 Old
<b>a</b>	KOE = a		1/1/2/19/10	L MO0153	Alexandria Ferry	Rd, Clinto	n, MD 2073	5
			23a. Pan1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Do not one cause on each line.	enter the mode of dying, such as ca	rdiac or respiratory are	rest,	Approximate Interval Between
P	hysician		Immediate Cause (Final disease or condition	CONGESTIVE	HEART FAIL	URE		Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of)		_		·
E	xaminer		Sequentially list conditions,	b. LLATED	CARDIOMYO	ATUY		
70	, <del>4</del>	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of)				
cute	ind	am	Cause (Disease or injury that initiated events resulting in death) Last	С.				
0, 8	ysicien and le burial-transit		resulting in death) Last	Due to (or as a consequence of)				
8760,	physic the b	Physician/Medical	•	d				
6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6	e as	Mec	IF FEMALE:	A . V . S . L . S . D . S . D . D . D . D . D . D . D				
Box	attending I	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of deliv Month	ery Day Year
0	by the a	sic	1 ☐ Yes 2 ☐ No 9 ☑ Inknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)			Day . Ou.
O. 1	ed by detac	F.	Part II. Other significant conditions of	antibuting to death but not regulting in the	an underhing anuse given in Red I	23e Did to	bacco use contribute to t	he cause of death?
S,	signed be del	þ	Part II. Other significant conditions of	Millipoling to death but not resulting in the	ie underlying cause given in Part I.		es 2 No 3 Pro	
O'C	been s	ted				- '-	es 2 140 3 F10	Dably 4 Chknown
<b>U</b>	2 0	1 20 1				24a. Was a autop	sy prior to co	psy findings available impletion of cause of
ecc by	hast pe2s	ᅙ					med? death?	
Il Records, P.O. Box 68760, The law requires that the death certificate be executed		Compi				perfor 1 ☐ Yes	2. No 1 ☐ Yes	2. No
/ital Reco		Be Completed by	25. Was case referred to medical examiner?				2 No 1 ☐ Yes	
of Vital Reco		To Be	examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp	atient 3 DOA Other: 4 Nursi	1 ☐ Yes  Death (Check only of  ng Home 5 ☐ Resid	2 No 1 Yes ne) ence 6 Other (Speci	2 <b>X</b> No
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of Vital	this certifice al director, I	To Be	examiner? 1 Yes 2 XNo  27. Manner of Death 1 XNatural 5 Pending	28a. Date of Injury (Month, Day Year)  28b. Tim	atient 3 DOA Other 4 Nursi ne of 28c. Injury at Work? M 1 Yes 2 No	☐ Yes  Death (Check only or  ng Home 5 Resid  28d. Describe h	2 No 1 Yes  The)  ence 6 Other (Special own injury occurred  treet and Number or Run.	2 <b>)</b> XNo
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of Vital	this certifice al director, I	Certification: To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined  29a. Certifier (Check only one)  1 Certifying Physical Examone)	28a. Date of Injury (Month, Day Year)  28b. Flace of Injury - At home, farm building, etc. (Specify)	Attent 3 DOA Other: 4 Nursing	Death (Check only or ong Home State Pasid 28d. Describe h	ause(s) and manner as slate and place, and due to	al Route Number,
of Vital	this certifice ral director, I	To Be	examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury 28b. Tim Injury 28c. Place of Injury - At home, farm building, etc. (Specify)  28c. Place of Injury - At home, farm building, etc. (Specify)  rsician: To the best of my knowledge, cliner: On the basis of examination and/cliners and manner stated.	Attient 3 DOA Other: 4 Nursing attient 3 DOA Other: 4 Nursing attient and provided at the time, date and provincestigation, in my opinion, death and provincestigation, in my opinion, death and provincestigation.	Death (Check only or ong Home SCI Resided 28d. Describe home 28f. Location (SCity or Towns) and due to the concurred at the time, on the concurred at the time, or concurred a	ause(s) and manner as s	al Route Number,
of Vital	within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification: To Be	examiner?  27. Manner of Death    Natural   5   Pending investigation	28a. Date of Injury 28b. Tim (Month, Day Year)  28e. Place of Injury - At home, farm building, etc. (Specify)  rsician: To the best of my knowledge, of iner: On the basis of examination and/of and manner stated.	atient 3 DOA Other 4 Nursi	Death (Check only or ng Home SQ Reside 128d. Describe home 28d. Describe home 28f. Location (SCify or Townstate, and due to the coccurred at the time, coccurred	ause(s) and manner as slate and place, and due to the signed (Month,	al Route Number,
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of Vital	withing thousand mentaling righteren, withing thours after death.  To the Funeral Director: After this certification of completely filled in by the funeral director, it	Certification: To Be	examiner?  27. Manner of Death    Natural   5   Pending investigation	28a. Date of Injury 28b. Tim Injury 28c. Place of Injury - At home, farm building, etc. (Specify)  28c. Place of Injury - At home, farm building, etc. (Specify)  rsician: To the best of my knowledge, cliner: On the basis of examination and/cliners and manner stated.	atient 3 DOA Other 4 Nursi	Death (Check only or ng Home SQ Reside 128d. Describe home 28d. Describe home 28f. Location (SCify or Townstate, and due to the coccurred at the time, coccurred	ause(s) and manner as slate and place, and due to the signed (Month,	al Route Number,

			State of Maryland / Department of H			11115	39308
	0.		State Registrar Certificate of I		Reg. Ne	.000	3. Time of Death
7	Physicia	an	GEORGE EUGENE PODOLAK		onth 4Day	2 005	5 11:15 QM
	/Medic	- 0		or Location of Death	40,	County of Death	
-	Examin	e:	Franklin Square Hospital Rose	dale	1	soult	imole
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under Year Months Days	If Under 24 Hrs. 8. Da Hours Min. (M	te of Birth onth, Day, Year)	9. Birth	nplace (State or Foreign untry)
	Director		214-30-5750   14   84   Yrs.	JUN	E 2, 19	21 UK	RAINE
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		<u> </u>		10d. Inside City Limits
	Mary f aho	ţ	MD. BALTIMORE PARKVILLE				1 □ Yes 🎢 Mo
2	rs after death with the Maryland ", or Items 23e or 28e-f show Raminer must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Cit	lizen of What Co	untry?
0	th witi	aiΩ	2428 ELLIS ROAD 212	234		U.S.A.	
5)	r death	ner		Hispanic Origin? (Specify Yean, Mexican, Puerto Rican,	es or No- etc.)	<ol> <li>Race - Amer Black, White</li> </ol>	
98	s afte	<b>Бу</b> Ft	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Year or Dates:	Specify:		Specify: Tall	ITE
000	72 hours after death w *natural; or items 23a		15. Decedent's Education 16a. Decedent's Usual Occup	pation	16b. K	(ind of Business/l	
7,5		Completed	(Specify only highest grade completed) (Give kind of work done life. DO NOT use retired life. DO NOT use retired	during most of working d)			
<u>~</u> ₹	giene giene	Com	5+ CHEMIST			S. ARM	Y
不后	be file ital Hy d oth	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First		Sumame)	
ylan	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, Ita Mi	2	PETER PODOLAK  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street		ECIZ	Town State 3	Tin Codel
Mar	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 Is marked other then other traumatic event, Ite M	1					
0 0	1 and Healt am 2		DR. ROMAN PODOLAK/SON  2820 ASPEN  20a. Method of Disposition  20b. Place of Disposition (Name of cemetary, crematory or other place)	Date		ocation - City or	
700	ages ant of it: If it		1 XBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  ST. MICHAEL'S U	l l	2/8/05	ם אד תידו	MODE MD
altimor	permit. Pages Decartment of the content of the content: If its any injury or of one			ess of Facility ZEILER INC			
Ä	De a la contra del		1901 EAS	STERN AVENU	E, BALT	IMORE.	ME MD. 21231
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyir shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Land Company (Final)				Onset and Death
	/Medical		disease or condition resulting in death)  a.   Myocurdial inforction  Due to (or as a consequence of):				
3.3	Examiner	L	Sequentially list conditions, b.				
1	ed isit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
V	xecut and al-trar	Examiner	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
8760	ate be executed hysician and the burial-transit		C d				
	lificate g phys as the	Physician/Medical					
Box 6	eath certific attending pi for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnance	:v		23d. Date of deli Month	
9.	that the death certific ed by the attending p detached for use as	sicis	in the past 12 months?  1   Yes 2   No   Pregnant at time of death 5   Other (specify)			WOUTH	Day Year
P.O.	d by t	Phy	9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I	3e. Did tobacco	use contribute to	the cause of death?
, S	ires tha signed d be del	1 by	A cute renzi failure, Atrial Fibrilation			. □No 3 □ Pro	
000	requires been sign should be	etec	·	2	4a. Was an	24h Were au	tonsy findings available
ě	ne tav a has ge 2	Completed by	Congestive Heat failule		autopsy performed?	death?	topsy findings available completion of cause of
<u>a</u>	ician: Th certificate rector, pag		25. Was case referred to medical	26. Place of Death (Che	Yes 2 No	) 1 Yes	2 No
>	ysicie s cert direct	To Be	ayaminer?	her: 4 Nursing Home		6 ☐Other (Spec	cify)
0	ding Phys	T:U	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury	ry at 28d. C	Describe how inju	iry occurred	
io	tending Physician: The seath. tor: After this certificate ha the funeral director, page	atic	2 Accident investigation M 1	Yes 2 □No			
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street a lity or Town, Stat		ural Route Number,
۵	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Ce	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the ti	me date and place and di	ie to the cause(s	and manner as	stated
	24 hc 24 hc Fun etely	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my one and manner stated.	opinion, death occurred at	the time, date an	d place, and due	to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier 29c. License	se number	29d. Da	ate signed (Montl	h, Day, Year)
			7, 1, 0, dos 20, 4, n	045789	12	14/20	305
	10					7-1-1	
_	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Wilbur R. R.O.C.S.O. M.O. 4701 Foli Crton A  31. Date filed (Month, Day, Year)  32. Registrar's Signature	wenve, Bz	Himale	, MO 2	1236
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrár's Signature				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Deeth 1. Decedent's Name (First, Middle, Last) <sup>Day</sup>22 **Physician** 2005 November 10:35AM Izetta Pinkney /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Locetion of Deeth 4c. County of Death Examiner Annapolis Anne Arundel Heritage Harbour Health & Rehab If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Apr 19 9. Birthplace (State or Foreign Country)
N. Carolina 7. Age (In yrs. lest birthday) 5. Sociel Security Number 6. Sex Year) 932 **Funeral** 1 ☐ M 21 ☐ F Days 73 Director 239-46-6900 Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Merylend nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. Stete Department of Health and Mental Hygiene. Institute it is the 23a or 28a-f show important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No Edgewater Directo Maryland Anne Arundel 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street end Number 21037 TISA 428 Mill Swamp Rd. Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Merital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: Black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Teacher's Aid 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Eugene Haywood Hoskins Betty Corrina Lewis 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) William A Pinkney III(Husband) 428 Mill Swamp Rd. Edgewater, Md. 21037 20b. Place of Disposition (Name of L. Refreem Gardon M. Charleton Date 2 a 1 20a. Method of Disposition 20c. Location - City or Town, State 1 NBurial 2 Cremetion 3 Removal from State 11-26-05 Davidsonville, Md 4 ☐ Donetion 5 ☐ Other (Specify) Gardens 21. Signature of Funeral Service Licensee 22 Name and Address of Facility.
Wm. Reese & Sons Mortuary, P.A. 821 West St. Annapolis, Md. 21401 Zax Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eegh line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) 6 **Examiner** Due to (or as a consequ Be Completed by Physician/Medical Examiner or Attanding Physician: The lew requires that the death certificate be executed use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Division of Vital Records, P.O. Box 68760. resulting in death) Last After this certificete hes been signed by the etter funerel director, page 2 should be deteched for 23b. Did tobacco use contribute to the cause of deeth? Part II. Other significent conditions contributing to death but not erlying coush given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 1 🗆 Yes 2 000 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 20 NO Other 3□ DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 28c. Injury a Work? 27. Menyrter of Car 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred I Director: After the in by the funere Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 29a. Certifier (Check only one) ritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. 2 Medicaf Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the ceuse(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Yeer) 29c. License number 30. Name end eddress of person y no completed cause of death (Item 23e) (Type, Print) CHANDO 8 0 MID

Registrar **DHMH 16 Rev 6/95** 

State

31. Date filed (Month, Day, Year)

32. Registrer's Signature

Michael J. Patak 95-8136

KG

		State of Maryland / De State of Maryland / De Registrar	partment of Health and least me G850 12-12- efficate of Death	Mental Hygie -05 tas	2°005 39310
Physici /Medic		Decedent's Name (First, Middle, Last)     MICHAEL	PATAK	2. Date of Death Month Decembe	Day 2, 2005 3. Time of Death 5:50 P M
Examir		4a. Facility Name (If not institution, give street and number) 7926 Stevenson Road	4b. City, Town, or Location of Death Pikesville		4c. County of Death Baltimore County
Funeral Director		5. Social Security Number  218-40-0223  0. Sex  1	Months   Davs   Hours   Min.	8. Date of Birth Month Day 9	9. Birthplace (State or Foreign Country)
death with the Maryland ms 23s or 28e-f ehow Imust be notified at	tor	10a. State 10b. County 10c. City, Town of MD BALTIMORE BALTIN			10d. Inside City Limits 1 ☐ Yes 2☐ No
ith with the Ma 23a or 28e-f	i Direc	10e. Street and Number 7926 STEVENSON ROAD	10f. Zip Code 21208	100	g. Citizen of What Country?
<u> </u>	by Funeral Director		3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1  Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: WHITE
i within 72 jene. r then "na	Completed	(Specify only highest grade completed) ((Specify only highest grade completed)	scedent's Usual Occupation live kind of work done during most of wor ie. DO NOT use retired)	rking	Sb. Kind of Business/Industry  UILDING PRODUCTS
d 2 should be filed the and Mental Hygis i? Is marked other treumatic event,	To Be C	17. Father's Name (First, Middle, Last)  MIKE PATA		me (First, Middle, Ma	uiden Sumame) UDOFF
end 2 shou leelth and M m 27 is mar her treumat	·		ailing Address (Street and Number or Rt S STEVENSON ROAD -		City or Town, State, Zip Code) , MD. 21208
of H		20a Method of Disposition 20b. Place of D	sposition (Name of crematory or other place)	Date 20	Oc. Location - City or Town, State
permit. Pag Depertment Important: eny Injury o		21. Signature a Funeral Service Licens  23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	22. Name and Address of Facility	I LEVINCO	OWSON, MD N & BROS., INC. KESVILLE, MD 21208
The law requires that the death certificate be executed with the death certificate be executed with the attending physician and page 2 should be detached for use es the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Oxycodone intoxi  Due to (or as a consequence of the cause (Disease or injury that initiated events resulting in death) Last  Oxycodone intoxi  Due to (or as a consequence of the cause (Disease or injury that initiated events resulting in death) Last	cation		Interval Between Onset and Death
hat the death certifi Id by the attending setached for use es	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
w requires that been signed b should be deta	ed by PI	Part II. Dther significant conditions contributing to death but not resulting in t  Carcot-Maria-Tooth Disorder	ne underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	accoluse contribute to the cause of death?
i: The law re icete hes bei r, page 2 sho	Completed by				No 1 Yes 2/2 No
or Attending Physician: The law requires telefor death. Director: After this certificate hes been signe in by the funeral director, page 2 should be	ion: To Be	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury 28b. Tir	atient 3 DOA Other: 4 Nursing he of 28c. Injury at	28d. Describe how	ice & Other (Specify) at scene vinjury occurred
To the Hospitel or Attend Within 24 hours efter death To the Funerel Director:	Certification:	2 Accident 3 Suicide 4 Homicide  1 Homicide  2 Accident 5 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)  1 Found at home	d p	28f. Location (Stre City or Town,	ingested drug set and Number or Rural Route Number, State <b>7</b> 926 Stevenson Road Le, Maryland
To the Hospitel or Within 24 hours effe To the Funsrel Dir	Medical (	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, 2 Medical Exeminer: On the basis of examination and and manner stated.			
To the H Within 24 To the Fu	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	290 De	d. Date signed (Month, Day, Year) ecember 3, 2005
Kalan.		Sheet the 1110 min.	Penn Street, Baltim	ore, Mary	land 21201
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 6 2005	Soulis		

			For Stata Registrar	State of Mar	-	artment of H		nd Mental Hy	giene 05	39311			
	A	· w	1. Decedent's Name (First, Middle, Las	1)				2. Date of De Month	ath Day Ye	3. Time of Death			
	Physici /Medic		Carl	5.	R	ichards	27	Decemb		05 083 AM			
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o		Death	4c. County of D	eath			
4		<u>ب</u> ج	The Johns Hopkin	5 HOSPITAL		Baltin	we c	ity					
	Funeral		5. Social Security Number 6. Se	X 7. Age XM 2 ☐ F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min. NOV 5,	th 9.	Birthplace (State or Foreign Country)			
	Director		217-38-8542 Usual Residence of Decedent		66 Yrs.			NOV 5,	1939 M	larýland			
	and w	-	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits			
	daryl f sho	ō	MD Baltin	nore		Cat	onsvi	.11e		1 ☐ Yes 2 <b>X</b> No			
	289	rect	10e. Street and Number			10f. Zip Code			10g. Citizen of What	t Country?			
	3a or	Ö	7 David Lee Co	ourt			2122	.8	USA				
	within 72 hours atter death with the Maryland ene. Then "naturel", or items 23a or 28e-f show the Modical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H	lispanic Origi	in? (Specify Yes or No Puerto Rican, etc.)	14. Race - A	American Indian,			
9	or its	Ī	1 Never Married 2X Married	1 XiYes 2 ☐ No	1957-	1 ☐ Yes 2 💢 No	Specify:	ruello filoati, etc./	Specify:	Vhite, etc.			
215-0036	in 72 hours in 72 hours in "naturel", o	d by	3 Widowed 4 Divorced	Year or Dates:	1977					White			
5-(	72 h	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done	during most o	of working	16b. Kind of Busine	,			
121	hen hen	mpi	Elementary/Secondary (0-12)	College (1-4or 5+	)	DO NOT use retired ronics To	•	i an	Electron: Manufact				
N	be filed withing tal Hygiene. d other then event, the M		17. Father's Name (First, Middle, Last)		Hice	TOTILED I		's Name (First, Middle		ur IIIg			
anc	ould be f Mental I arked of atic evs	Be	Carl W	. Richards	son				Selby				
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other then other traumatic event, Ita M.	2	19a. Informant's Name/Relationship (	vpe, Print)	19b. Maili	ng Address (Street	and Number	or Rural Route Numb	er, City or Town, Sta	te, Zip Code)			
Ma	and 2 saalth ar n 27 is er trau		Patricia A. Richa	rdson. wife	e 7 Da	vid Lee	Cour	t Cato	nsville.	MD 21228			
ē,	is 1 and if Health Item 27 other tr		20a. Method of Disposition		20b. Place of Dispo			Date	20c. Location - City				
JU O	0 0		1 ☐ Burial 2 X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi					2/03/05	Baltimo	re, MD			
Baltimore	그 본 본 근				1								
ñ	Depa impo eny ir		George E. MacNabb 301 Frederick Road Catonsville,										
120			George E. MacNabb 301 Frederick Road Catonsville, MD 21  3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Approximate Interval Between										
	enysician		Immediate Cause (Final disease or condition			shoulent a	don	Co. co.: 4 sono b		Onset and Death			
	/Medical		resulting in death)		consequence of):	Medical O	CAELIC	Carcinomo		( Willes			
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8760	cate b	dica		d									
9 x	certificate be executed Iding physician and ise as the burial-transit	Me	IF FEMALE:	23c. If yes, outcome o	of pregnancy				23d. Date of	dolivon			
Вох	death of	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	у		Month	Day Year			
o.	the d	Physician/Medical	1 Yes 2 No	9□ Unknown		2 Gio. (apasy)							
Δ.	equires that the death certificate een signed by the attending phys tould be detached for use as the	P P	Part II. Other significant conditions of	ontributing to death but	t not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did 1	obacco use contribu	te to the cause of death?			
Records,	puires n sign	d by						1 🗆	Yes 21 No 3	Probably 4 Unknown			
S	N D TS	Completed						24a. Was	an 24b. Wer	e autopsy findings available to completion of cause of			
Re	The la	mc							ormed? deat	to completion of cause of h? Yes 2□ No			
Vital		0	25. Was case referred to medical				26. Place	1 ☐ Yes of Death (Check only		165 2 140			
<u>&gt;</u>	Physicien: this certific ral director,	To B	examiner? 1 ☐ Yes 2.⊠No	Hospital:	nt 2 ER/Outpatie	nt 3 DOA Ott	or	sing Home 5 ☐ Resi		Specify)			
Division of	g Phys er this neral di		27. Manner of Death 1 Xatural 5 ☐ Pending	28a. Date of Injury (Month, Day		of 28c. Injur	ry at	28d. Describe	how injury occurred				
jor	ath. or: Afi	atio	2 Accident investigation	1	,		Yes 2 □ N	lo					
Νį	er de recto	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ry - At home, farm, st (Specify)	reet, factory, office		28f. Location ( City or To	Street and Number own, State)	r Rural Route Number,			
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	S											
	Hosp 4 hou Fune ely fil	edical	(Check only 2 Medical Exar	ysician: To the best of ninar: On the basis of	examination and/or in								
	the hin 2 the l	Med	one) 29b. Signature and title of certifier	and manner stat	ed.	29c. Licens	se number		29d. Date signed (A	fonth Day Year)			
	To Yell		255. Signature and this of certified							HE:			
	(x)		Cottonine Com		ath (Itom 22a) (Trans		ODU		Diember 3	3 2015			
	12		30. Name and address of person who	The Tales	11-04-05	11a5a11-1	lock : 2	We hande	troval On 11	- 00 000 212 67			
- 63		ate	31. Date filed (Month, Day, Year)	32. Posistra	r's Signature	Man Man	ww No	IN MORE 3	HER DULL	MOLE INIT SIEGI			
	Regist		DEC 0 6	32. F. Sistra	ia S. p	DE VELO							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Dev Year Physician - 03PM RENFREW 2005 DAMES /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County Brightwood Center Lutherville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb. 28, 192 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Deys 1**∆**M 2□ F 84 Yrs. 268-12-7174 Wilson, PA. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. Stete 10b. County 1 ☐ Yes 2 No Glen Arm Maryland Baltimore County Funeral Directo 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 28 Deer Woods Court 21057 United States 12. Was Decedent Ever in U,S. Armed Forces? 1≜Yes 2 ☐ No W•W•II If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3₺ Widowed 4 Divorced 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Representitive IBM Corp. 04 18. Mother's Name (First, Middle, Maiden Sumame) 17 Fether's Neme (First, Middle, Lest) Luther Renfrew Jessie Oliver 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Susan L. Frech (Daughter) 16 Deer Woods Court 21057 Glen Arm, Maryland 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans Dec.12,05 Owings Mills,MD. 4 ☐ Donation 5 ☐ Other (Specify) Peaceful Alternatives Funeral&Cremation Ctr.,P.A.
2325 York Road Timonium, Maryland 21093 2325 York Road The dise se, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause where the death in each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final INTRA CRANIAZ disease or condition resulting in death) Examiner Due to (or as e consequence of): Physician/Medical Examiner RENAC 7 E or Attanding Physician: The law requires that the death certificete be executed the attending physician and hed for use as the buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. director, page 2 should be detached 3 Probably A Onknown 1 ☐ Yes 2 ☐ No á Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? peed completion of cause of death? 1 ☐ Yes 2 ☐ No 1 765 2 110 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 ☐ Yes 2 ☐ 1√0 this Director: After this d in by the funeral 28e. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1. □ Naturel 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifier up te MD D0023120 736. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) treso read halevnmale WON ON 31. Dete filed (Month, Day, Yeer) 32. Registrar's Signature State 6 2005 Registrar DECO

State of Maryland / Department of Health and Mental Hygiene 39313 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death December 05, 2005 **Physician** 11:00 A.M Katharina Mina Ruckman /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County 5001 Carroll Manor Road Baldwin If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Sept. 15, 1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Months 88 216-32-3891 Director Germany Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show item 27 is marked other than "neturel", or itama 23a or 28a-f show other treumatic event. Its Madical Examinar must be notified at 1 ☐ Yes 2 No Baltimore County Baldwin Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21013 5001 Carroll Manor Road United States Funeral deeth 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "neturel", or item any injury or other treumatic event, the Medical Exeminations. Bleck, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: by White 3- Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Collections Dept. n/a Montgomery Ward 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Monteur Hermann Adolf Mettler Anna Katharina Frank 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2770 South Via del Bac Green Valley, AZ. 85614 Mrs. Renate Lee (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Evans Funeral Chapel Dec.07,2005 Forest Hill Maryland 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service License Peaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road Timonium, Maryland 21093 21. Signature 23a. Part 1. Enter the disease sheek, or heart failure. U b, br complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio Pnysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner HT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the attending physicien and ned for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 M No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pendina s after death. 1 ☐ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospitel within 24 hours a To the Funerel 6 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title D143 21131 completed cause of death (item 23 Date filed (Month, Pay, Year) istrar's Signature.... State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			. For	State of Marylan				and Menta	-	_	
			1 - Stete Registrar		Ce	tificate	of Death		Reg. N	2005	39314
	Physici	an	1. Decedent's Name (First, Middle, Last)	• 0				2. Dat	e of Death nth D	ay Year	3. Time of Death
	/Medi	cal	- Donald	O. Kudin		U 03 T				3 Z00°	5 0700 M
	Examir	ner	4a. Facility Name (If not institution, give:	eek		0-	wn, or Location of	On a la	4	c. County of Dea	ath .
	Funeral		5. Social Security Number 6. Sec	7. Age (In yrs. I	ast birthday)	If Under 1 Y		24 Hrs. 8. Dat	e of Birth onth, Day, Yea	9. Bi	rthplace (State or Foreign
L.	Director		5/0-10-2596	82 82 82	Yrs.	Months D	ays Hours				vaii
	land DW		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary a-f sh	tor	MD Anne Aru	nde1	Annap	olis					1 ☐ Yes 2 ☐ No
	ith the	Jirec	10e. Street and Number			10f. Zip Co	ode		10g. C	itizen of What C	ountry?
	ath w	rai	208 Victor Parkw	_ <del>-</del>			2140			JSA	
	ter de items	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.: Armed Forces?	S. 13.	Nas Decedent f Yes, specify	t of Hispanic Orig Cuban, Mexican	gin? (Specify Ye i, Puerto Rican, e	s or No- etc.)	14. Race - Am Black, Whi	
99	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Examirac must be notified at	by	3 Widowed 4 Divorced	1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 152-	.54	1□Yes 2∏X	No Specify:			Specify: W	hite
21215-0036	72 hc	Completed by	15. Decedent's Edu (Specify only highest grade	cation	16a, Dece	lent's Usual C	occupation lone during most etired)	t of working	16b.	Kind of Business	s/Industry
121	within iene.	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)							
	Hygie other	a l	12 17. Father's Name (First, Middle, Last)	5+	phy	sician		r's Name (First,			research
<u>lan</u>	Mental larked o	To B	Henry Albert Rudi	.n			Gerti	rude Cla	ire Wo	odill	
Maryland	2 should and Men is marke eumatic	0 1	19a. Informant's Name/Relationship (Ty				treet and Numbe	r or Rural Route	Number, City	or Town, State,	Zip Code)
	1 and Health tem 27 other tr	1 3	Joan Rudin/spouse			Victor	Parkway		-		2102
Jor	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Health and Mental Hygiene. ortent: if item 27 is marked other then "natural", or items 23s or 28s-f show injury or other treumatic event, the Mastical Examirer must be notified at 8.		1 ☐ Burial 2 ☐ Cremation 3 ☐ R			natory or othe		Date	20c. l	ocation - City or	Town, State
Baltimore,	permit. Pages 1 and Department of Health Importent: If item 27 eny injury or other tr once.		4 N Donation 5 ☐ Other (Specify)  21. Signature of Euneral Service Licensu RODA Ltd S. W	10 6 / 1 / 1		. Name and A	ddress of Facility	у	10.1		
m	Depa impo eny ii		(nail)	ade Ditector	St	ate An	atomy Bo	oard 655	W. Ba	ltimore	Street
			23a. Parti. Enter the disease, or complished or heart failure. List only or	cation hat caused the death	. Do not ent	or the mode of	dying, such as	cardiac or respir	atory arrest,		Approximate Interval Between
	Physician		Immediate Cuse (Final disease or condition resulting in death)	Cood	iac	thr	4/bomi	(a			Onset and Death
	/Medical Examiner		rosuling in douting	Due to (or as a consequ	ence of):	5 1	tous				
	- 4	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ence of):		W.W.				
	cuted nd transit	Examiner	that initiated events								
8760,	death certificate be executed e attending physician and of for use as the burial-transit		resulting in death) Last	Due to (or as a consequ	ence of);						
687	physicate to physical	Physician/Medical									
Box (	attending p for use as	□/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnar						23d. Date of de	livery
	ne death the atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown		Ectopic pregn Other (specif				Month	Day Year
P.0	that the de ed by the detached	Phys	9 Unknown		441 1 41				7		
ds,	es De de	d by	Part II. Other significant conditions con	Impuling to death but not resu	ning in the ur	idenying caus	e given in Part I.	236	o. Did tobacco 1 ☐ Yes 2	_	o the cause of death?
Records,	w requir been si should	Completed			-			243	ı. Was an		
Re	The lay	фшо						_	autopsy performed?	prior to	utopsy findings available completion of cause of
Vital		Be C	25. Was case referred to medical				26. Place	of Death (Check		1 □ Yes	: 2□ No
of V	Physicien: this certificatal director,	일	1 185 2 100	ospital: 1 ☐ Inpatient 2 ☐ E	ER/Outpatien			rsing Home 5	Residence	6 ☐ Other (Spe	cify)
	ding Ph h. After thi funeral	lon:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		Injury at Work?		scribe how inju	ry occurred	
Division	deat deat ctor: / the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	ne, farm, stre	M eet, factory, of	1 ☐ Yes 2 ☐ N		ation (Street a	nd Number or Ri	ural Route Number.
=	n ji te	Certification:	4 Homicide determined	building, etc. (Specify,	)			City	or Town, State	9)	ara riobio riombor,
	To the Hospitel within 24 hours a To the Funeral c completely filled i	edical (	29a. Certifier 1 Certifying Phys	icien: To the best of my knowner: On the basis of examinati	vledge, death	occurred at the	ne time, date and	d place, and due	to the cause(s	) and manner as	s stated.
	thin 2, the F	Med	29b. Signature and title of certifier	and manner stated.	-		cense number				
7	Z ¥ Z 8		11 -	hotora.		NS	7000		h /	te signed (Mont	n, Day, Year)
•			30. Name and address of person who co	mpleted cause of death (Item	23a) (Type.	Print) /			/	~ 1/~	
			Aditya Chopra	Genesis	Six	- life	ek, ar	mapor	15, 1	10	
	Sta Registr		31. Date filed (Month, Day, Yedr)	32 Registrar's Signat	ure	contra de	,	,	, ,		

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 8:45 A<sup>M</sup> 4, 2005 December Reizmann /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Rowie 4015 Ayden Court If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 💢 F Yrs. Feb 23, 1921 Director Germany 84 213-76-4487 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a. State 10b. County or 28a-f show the Medical Exacitive must be collified at 1 ☐ Yes 2 X No Prince Georges Bowie Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23e United States 20721 4015 Ayden Court Funeral death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. a filed within 72 hours after I Hygiena. other then "naturel", or Itel 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White ۵ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should ba fill and Mental F Be traumetic Adelheid Katz Winter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an item 27 I Bowie, Maryland 20721 4015 Avden Court other t Daniela Milstein/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Importent: If it eny injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Arundel Crematory 12/6/2005 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A. 21. Signature of Funeral Service Licenses H19mas M00957 1411 Annapolis Road Odenton, Maryland 21113 uanita 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 weeks Physician Cerebral Vascular Accident /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Jusease of Injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death cardificate be exacuted burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760 Completed by Physiclan/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 XNo be detached o the 9 Unknown 9 Unknown Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☼ No page 2 s 2[XNo 1 Tes 2 🔀 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ۲ 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No death. 2 Accident after death the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide 2 Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 December 5, 2005 D34403 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew S. Dobin, M.D. 4175 North Hanson Court Suite 203A Bowie, Maryland 20716 31. Date filed (Month, Day, Year) 3. Registrar's Signature 6 2005 0 Registrar

		ŀ	1 - For State Registrar	State of Marylan		artment of H			iene g. No	05	39317
	Physici	an	1. Decedent's Name (First, Middle, Las	Rubinson				2. Date of Dear Month	Dav	Year	3. Time of Death 5: 55 A M
,	/Medic Examin		4a. Facility Name (If not institution, give Murylane Ceneral	street and number)		4b. City, Town, or Baltimay		th		05 hty of Death	
	Funeral Director		5. Social Security Number 6. S 214-28-3274 1		ast birthday)  3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min			9. Birth	place (State or Foreign ntry)
	daryland f show	or	Usual Residence of Decedent  10a. State 10b. County  MD Bulthmax		y, Town or Lo						10d. Inside City Limits 1    Yes 2 □ No
	death with the Maryland me 23a or 28a-f show croust be rediffed at	i Director	10e. Street and Number  3722 Polifield			10f. Zip Code 2/2/5		1	Og. Citizen		ntry?
	or ite	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates:	1	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	E	lace - Ameri lack, White, city: A.f.	
	nin 72 hours n "natural", Medical Ex	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) Coltege (1-4or 5+)	(Give	dent's Usuat Occupa kind of work done d DO NOT use retired;	luring most of wa	orking	16b. Kind of	Business/Ir	ndustry
7 7	led with tygiene her the		12 TH GRADE	4 YRS	37918	MS ANAL					URITY
and	id be fi entat H ked ott ic ever	To Be	17. Father's Name (First, Middle, Last)	WOK		1		me (First, Middle, 1 TH FALLI		ame)	
, mary	aith and Maith and Martin and Mar	_	19a. Informant's Name/Relationship (1) PAMELA D. SMMH			NEW OAL	and Number or R	ural Route Number	City or Tox		o Code)
nore	ages 1 and nt of Healt t: If Item 2		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	emetery, crei	matory or other place	э)			- ,	own, State
altil	armit. P apartme aportan ny injury		4 □Donation 5 □ Other (Specify 21. Signature of Fuperal Service Licen		ENMO	Name and Addres			BALTO.		
D	80 E # 9		23a. Part1. Enfer the disease, or compshock, or heart failure. List only	Discations that caused the death	51	51 BAUD. N	ATL PIKE	BALTO . MD	21229		Approximate
	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eyents	b. Due to (or as a consequence of the consequence o	t asc uence of): s/cn uence of):	cendary ac	ertic a	newy5m			Interval Between Onset and Death
-	ysicien ysicien	icai	resulting in death) Last	d	uence of):	,					
O. Box	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	Ideath 3[	Ectopic pregnancy Other (specify)				Date of deliv Month	ery Day Year
S,	requires that the sear signed by hould be detact	Ď	Part II. Other significant conditions o	ontributing to death but not resi	utting in the u	nderlying cause give	en in Part I.	23e. Did tot	•		he cause of death?
Hec	The lar ate has page 2	Completed						24a. Was a autops perform	У	o. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available impletion of cause of
VITAI	Physicien: this certific ral director.	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		othe Othe		ath (Check only on			
	ding Phy. h. Atter this funeral d	-	27. Manner of Death   Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	f 28c. Injury Work	at	dome 5 ☐ Reside 28d. Describe ho			<u>(v)</u>
DIVISION	To the Hospital or Attending Physicien: inin 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be 4 Homicide determined	1		reet, factory, office		28f. Location (St City or Town		mber or Run	al Route Number.
	e Hospital or Al 124 hours after of Funeral Directions of the property filled in by	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exen	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the tim vestigation, in my op	e, date and place pinion, death occu	e, and due to the caurred at the time, d	ause(s) and ate and plac	manner as s e, and due t	stated, o the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License		2	9d. Date sig	ned (Month,	Day, Year)
ر آ م	12		30. Name and address of person who	completed cause of death (Item	1 23a) (Tyne		4//		141,	105	
C	)		Heui You M.D.	5 Park Center	CT )	wite 200	· Own	gs Mills	2/1/	7	
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 6 2	32 Registrar's Signa	ture	and I					

		•	- For Amend Item 8 State of Market Registrar	350and	/ Departme -8-05 Cas Certifica	nt of Hea te of De	aith and M eath		Reg. No.	5 3	19318
3	Physicia	, an	1. Decedent's Name (First, Middle, Last)	7		. (		2. Date of De Month	Day	Year	3. Time of Death
	/Medic		MOSES Macka	4 1	AGA	N_		Decem		2005	1942 PM
- 3	Examin	er	4a. Facility Name (If not institution, give street and number)	1	4b. City	, Town, or Lo	cation of Death	2	4c. County	of Death	
100	S 16		he Johns Hopkins Ho 5. Social Security Number 6. Sex 7. Ag	OS PITO	of highway It lind		Under 24 Hrs.	8 Date of Bi	+h	0 Right	lace (State or Foreign
· 5.	Funeral Director		5. Social Security Number 6. Set 7. Ag 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	b ym yrs. ias	Yrs. Months		lours Min.	11-1-2	Year)	Cour	vland
)统。	壁		Usual Residence of Decedent			<u> </u>			.005	PICIL	yıaıd
	how		10a. State 10b. County	10c. City,	Town or Location					1	0d. Inside City Limits
	e Ma Sa-f s	cto	Maryland Harford	Bel	Air						1 ☐ Yes 2X No
	ith th	Dire	10e. Street and Number			ip Code			10g. Citizen of	What Cour	itry?
	s 23s	ra	802 Candlelight Drive, Apt.			21014	Osisis 2 /Cos	eit. Van ar N	USA	e - Americ	agn Indian
	Item	Funeral Director	11. Marital Status  12. Was Decedent Armed Forces?  1 Never Married 2 Married  1 Yes 2		If Yes, sp	ecify Cuban, N	anic Origin? (Spe Mexican, Puerto	Rican, etc.)		ck, White,	
936	urs at	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 🗆 Yes	XXNo S	Specify:		Specif	· Wh:	ite
21215-0036	72 hours after death with the Maryland natural, or items 23a or 28a-f show dital Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Us	ual Occupation	n ng most of worki	na	16b. Kind of B	usiness/In	dustry
21	within 7 ene. than "r	nple	Elementary/Secondary (0-12) College (1-4or s	5+)	life. DO NOT	use retired)	ng most of work	ng .			
7	e filed within al Hygiene. I other than 'vent, I'vent		0		Never Wo		Marked No.	(Circ. Mindale	Maidae Comme	1	
gu	be fill d oth	Be	17. Father's Name (First, Middle, Last)						, Maiden Suman		
<u>~</u>	2 should be and Mental Is marked raumatic ev	L	Michael Andrew Ragan  19a. Informant's Name/Relationship (Type, Print)	·	19b. Mailing Addres		Erinn	Noel.		Andre	
Maryland	d 2 si th an traur		Michael Ragan/Father		802 Cand				-		
dî.	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene.  I of Health and Mental Hygiene.  I of Health and Mental Hygiene.  I man 271s marked other than "natural", or items 23a or 28a-f show it man 271s marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at		20a. Method of Disposition	20b. Pla	ce of Disposition (N	ame of		ate	20c. Location		
9	ent of ent of nt: If i		1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	_	netery, crematory or Lington Ce		12-7	<b>-</b> 05	Darling	ton,	Maryland
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot ance.		21. Signature neral Service Licensee		22. Name a	and Address o	of Facility	De To		•	
ä	Depa Depa Impo any is		rests // Nevers		1317 (	is run. Cokesbi	eral Hom ery Road	l, Abin	gdon, Ma	rylaı	nd 21009
<b>类</b> -			23a. Part I. Ever the disease, or complicitions that cause shock, or heart failure. List only on- cause on each li	d the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		tricular		anal				Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as				,,,,,,,				, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
н	Examiner	L.	Sequentially list conditions, b. Due to (or as	2 20000000	anno of):						
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8760,	death certificate be executed e attending physician and ad for use as the burial-transit		C <sub>d</sub>								
9	ifficate t g physii as the b	edic	9.								
Вох	eath certific attending pl	7	IF FEMALE: 23b. Was decedent pregnant  □ Live birth			pregnancy				te of delive	•
	the att	slcie	1 Yes 2 No						Mo	nth	Day Year
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	res tha signed be de	ρ	Part II. Other significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to death to a significant conditions contributing to a significant conditions contributing to a significant conditions contributing to a significant conditions contributing to a significant conditions contributing to a significant conditions contributing to a significant condition conditions contributing to a significant condition condition condition conditions c	out not result	ting in the underlying	cause given ii	n Paπ I.		Yes 2 No		ne cause of death?
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a	an: The l tificate ha tor, page			-			1200	1 □ Yes	2 No	1 🗌 Yes	2XNo
ξ	Sec.	o Be	25. Was case referred to medical examiner?  1 Tyes 2 No Hospital: 1 Inpatin	205	R/Outpatient 3□ [	Othor	6. Place of Death		one) idence 6 □Oth	os (Coos)	
of	Physic rethis aral d	-	27. Manner of eath 28a. Late of Inju	ury 2	28b. Time of	28c. Injury at Work?			how injury occur		<i>(</i> )
lon	Attending I ir death. ector: After by the funer	atlor	1 Natural 5 ☐ Pending (Month, Da 2 ☐ Accident investigation	y Year)	Inju <i>r</i> y M		s 2 □ No				
Division	¥ >	Certification:		jury - At hom tc. (Specify)	ne, farm, street, facto	ory, office		28f. Location City or To	Street and Numb	er or Rura	Il Route Number,
Ö	ital or A	Cer									
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in E	edical	29a. Certifier (Check only 2 Medical Examiner: On the basis of	of examination	ledge, death occurre on and/or investigation	d at the time, on, in my opini	date and place, ion, death occurr	and due to the ed at the time	cause(s) and ma date and place,	anner as s and due to	tated. o the cause(s)
	thin 2 the mplet	Med	one) and manner st 29b. Signature and title of certifier	ated.	2	9c. License nu	umber		29d. Date signe	d (Month.	Dav. Year)
	Z X Z		Wir on NI Med &	. 4. 4						-	
	12		30. Name and address of person who complete cause of	death (Item	23a) (Type, Print)	VE2	- 50 6		NECEV	NUE	c 02 200
			Nicole Shilkotski 60	O No	orth We	le a	Street	Ro	Himoro	Mn	2 02, 2009
100	Sta	ate		rar's Signatu	JL6	-	,		+ + + 1 - 19236	1'	
	Regist	rar	DEC 0 6 2005   A		1.24 B	)					

DHMH 17 Rev 1/2001

ORIGINAL

	*	•	For Stete Registrar	State of Ma	ryland		rtment of tificate o				ene 0 0 5	39319
			Decedent's Name (First, Middle)	Last)				, Doan		Date of Death		3. Time of Death
	Physicia		EMANUEL	- W	2	EEL	)		7	De Combe	1 4 20t	S 1:25 A. M.
	/Medic Examin		4a. Fecility Name (If not institution,	give street and number)	•		4b. City, Town	, or Location		1	4c. County of I	Death
	_xa	•	NORTHWEST 18	MSFITAL			RAN	DALL	STOWA	J	BALTI	MORE
	Funeral Director		5. Social Security Number 218–30–5999	6. Sex 7. Age 1 ★ M 2 ☐ F	(In yrs. last	t birthday) Yrs.	If Under 1 Ye Months Day		Min.	Date of Birth 09/16/3	9.	Birthplace (State or Foreign Country) MD
	g ,		Usual Residence of Decedent		10 0: 7							
	deeth with the Maryland ms 23a or 28a-f show Lisust be nutified at	_	10a. State 10b. County		10c. City, T							10d. Inside City Limits 1 1 Ves 2 □ No
	88-1-1 M	ecto	MD		BAL	TIMOR						
	Der 2	Funeral Director	10e. Street and Number 7238 PARK HGHTS	AVENUE			10f. Zip Code 21208			10	g. Citizen of Wha	it Country?
	18 23	era	11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	Vas Decedent o		rigin? (Speci	fy Yas or No-		American Indian,
	r ite	FE	1 ☐ Never Married 2 Marrie	Armed Forces? ed 1 Armed Forces?		lf lf	Yes, specify C	uban, Mexica	an, Puerto Ri	can, etc.)		White, etc.
3	hours after turel', or its al Exemine	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	53-56	1	□Yes 2x	No Specifi	y:		Specify: I	BALCK
ָר ה	be filed within 72 hours after deeth with the Marylar lat Hygiene. Ital Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Moulical Examilmer cust be notified at	Completed	15. Decedent' (Specify only highes		1	16a. Deced	lent's Usual Occ	cupation	st of working	1	6b. Kind of Busin	ess/Industry
V	within 72 ene. than "nai he Medic	ğ	Elementary/Secondary (0-12)	Cotlege (1-4or 5-	+)		kind of work do OO NOT use ret				ATITO MA	NUFACTURING
N.	a filed wall Hygier other the		17. Father's Name (First, Middle, L			- 1	Mater				aiden Sumame)	MOTACIUNING
= .	uld be fi Aental H rked of fic ever	To Be	JESSE REED	asi)				18. MOU		E WILLI		
<u> </u>	2 should and Men is marke sumatic	F	19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Mailin	g Address (Stre	et and Num	ber or Rural F	Route Number,	City or Town, Sta	te, Zip Code)
Š	tra tra		BETTIE REED/ WI	FE		7238	PARK I	IGHTS .	AVE. A	PT A, B	ALTO., N	D 21208
ē,	tem 2	Ì	20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of	o/ace)	Dat	e 2	0c. Location - Cit	y or Town, State
Ë .	Pages nent of int: If it iry or o		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				IN CEM		12/10/	05	BALTO.,	MD
	permit. Pages Department of I important: If its any injury or o once.		21. Signature of Funeral Service L	icensee	3.0	22.						SONS F.H., INC
		-	23a. Part1. Enter the disease, or	complications that caused	the death.	Do not ente					MD 212	Approximate
	Manadatan		shock, or heart failure. List of Immediate Cause (Final	only one cause on each lin	θ.					^		Interval Between Onset and Death
١	hysician /Medical		disease or condition resulting in death)	a Hors	VO (PY	YUM	mh	F- F	me	<u> </u>		
E	Examiner			RIPLO	do	T.C.	0.000	(				
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequer	nce of):	gr \cus					
	be executed sicien and burial-transit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events									
Ď	be execuicien and		resulting in death) Last	Due to (or as a	consequer	nce of):						
9/9	eath certificate be exattending physicien for use as the buria	dicai		d								
٥	death certificate e attending phys od for use as the	Med	IF FEMALE:									
X Q	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 Fetal de	ath 3	Ectopic pregna				23d. Date of Month	f delivery Day Year
5	the de	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	time of deat	h 5⊔	Other (specify)	)		· ·		130
τ .	hat if		Part II. Dther significant conditio	ns contributing to death bu	t not resultir	na in the un	deriving cause	given in Part	H.	23e. Did toba	acco use contribu	te to the cause of death?
cords,	w requires that the de been signed by the should be detached	d by	•	<b>3</b>		•	, , , , , , , , , , , , , , , , , , ,	<b>J</b>				Probably 4 Unknown
Ö	v requ been shoul	ompieted								24a. Was an	24h Wer	o autoney findings available
d)	m 90	E								autopsy perform	ed? deal	e autopsy findings available to completion of cause of th?
		ပိ	25. Was case referred to medicat					ac Di-	( D 4 - (		700 1 D	Yes 2□ No
<b>5</b> :	s certific firector,	O B	examiner?	Hospital:	nt 2 TEB	VOutpatient	t 3 DOA	Othor		Check only offe	/ ice 6 ⊡Other (	Spaciful)
ō	g Phys er this eral di	<b>-</b>	27. Manner of Death	28a Oate of Injur	y 28	3b. Time of		njury at Vork?			v injury occurred	Specify
DIVISION	death. ctor: Aft / the fun	atio	Natural 5 ☐ Pending 2 ☐ Accident investig		( Gal)	Injury		Yes 2	□No			
<u> </u>	r Atte er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		ry - At home	e, tarm, stre	et, factory, offic	ce	28	f. Location (Stre City or Town,	et and Number o	or Rural Route Number,
בֿ	itai o urs aft rai Di led in											
	To the Hospital or Attending Physician: inip 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medicai	29a. Certifier Certifying (Check only one) Certifying	g Physicien: To the best of examiner: On the basis of and manner sta	examination	edge, death n and/or inv	occurred at the restigation, in m	e time, date a ly opinion, de	and place, and eath occurred	d due to the cau at the time, dat	use(s) and manne e and place, and	er as stated. due to the cause(s)
	vithin 2 To the complet	Me	29b. Signature and title of certifier				29c. Lice	ense number		29	d. Date signed (N	fonth, Day, Year)
	2		Anta to	ř	111		1)4	397	7	De	combe.	142005
X	1		30. Name and address of person	who completed cause of de	ath (Item 2)	3a) (Type, I	Print)					4 2005
O,	1		Cypien Onis	min 301 k	OSNI	9/2	21/2	Glen	Sum	e. M	219	$\rho$ /.
	Sta		31. Date filed (Month, Day, Year)	32. Redistra	r's Signatur	e La d	Carl.					
	Registr	ar	DEC 0	3 2005	FRA A	J. All	A STATE OF THE PARTY OF THE PAR					

			State of Maryland	/ Depa		ealth and M	Mental Hy	•	39320
es es	Physici /Medic	al		stansb		Landing of Double	2. Date of Dea Month	ber 2, 200	3. Time of Death  5 / 20 M
k	Examin Funeral Director	er	4a. Facility Name (If not institution, give street and number)  1. Age (In yrs. last 578-30-1081   TXM 2 F   78	tal st birthday) Yrs.	4b. City, Town, or  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da) OCT 23	4c. County of Dec	inthplace (State of Foreign Country) DISTRICT
boelvie	show	tor	Usual Residence of Decedent  10a. State 10b. County 10c. City,  MD N/A	Town or Lo		timore			10d. Inside City Limits 1 XYes 2 ☐ No
And Mark the Maclace	or items 23a or 28a-1 show	Funeral Director	10e. Street and Number 501 W. Franklin Street		10f. Zip Code	21201		10g. Citizen of What C	
ă	or Ita	þ	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ▼ Yes 2 □ No If ★ Yes (Sive Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 1 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- pecify Yes or No- pecify Yes or No-	Specify:	
Maryland 21215-0036		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of wor )	king	16b. Kind of Busines  Grocery	
/land 2		To Be Co	17. Father's Name (First, Middle, Last)  Jessie Wakefield Stans	sbur		18. Mother's Nan	ne (First, Middle, Cgaret	Maiden Surmame) Croso	
o .	. Pages 1 and 2 should be tment of Health and Mental tant: If Item 27 is marked ( jury or other traumatic sv		Valerie J. Stansbury, daughte 20a. Method of Disposition 20b. Place 20b. Plac	er 12	-	worth Way	Woodb	er, City or Town, State, oride. Vir 20c. Location City o Baltimo	oinia 22192 or Town, State
Baltii	Departm Departm Importar any inju		21. Signature of Funeral Service Licensee George MacNat	22	2. Name and Addres	s of Facility 299	Fre ler		lto.,MD 21228
760,	hysician hysician and hysician and hysician and hysician and hysician and hysician hysician hysician hysician hysician hysician hysician hysician hysician hysician hybridization hybrid	Ilcal Examiner	23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a conseque conseque)	Obsolution of the contract of	10	Pulm.		1	Approximate Interval Between Onset and Death
O. Box 68	ine law requires that the death certifications to the attending phy page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnance 1 ☐ Live birth 2 ☐ Fetal deaded 4 ☐ Pregnant at time of deaded 9 ☐ Unknown	death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of d Month	elivery Day Year
rds, P.O.	been signed by should be detac	ed by Ph	Part II. Other significant conditions contributing to death but not resulting	ing in the u	Inderlying cause give	en in Part I.	1	obacco use contribute Yes 2 No 3 F	
al Reco	certificete has bee irector, page 2 sho	Complet					24a. Was autop perfo 1 ☐ Yes	prior to death?	autopsy findings available completion of cause of as 2 \( \text{No} \)
Division of Vital Records,	Attending Frity r death. ector: After this by the funeral d	Certification: To Be			of 28c. Injury Work M 1 ['	er: 4 □ Nursing H	28d. Describe	dence 6 Other (Sphow injury occurred	
_	e nospital or 24 hours afte e Funeral Diri	Medical Co	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowl one)  2 Medicel Examiner: On the basis of examination and manner stated.	ledge, deat on and/or in	th occurred at the time	ne, date and place pinion, death occu	, and due to the rred at the time,	cause(s) and manner a date and place, and do	as stated. se to the cause(s)
,	within 2 To the	Me	29b. Signature and title of certifier  65-67-68-7 M. F.		29c. License	9502		29d. Date signed (Mor	oth, Day, Year)
	3		30 Name and address of person who completed cause of death (Item 2)	90	Print) Mary	1/and	Gene	ral Ho	spital
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  32. Registrar's Signatu  DEC 0 6 2005	ire M_A	fords.				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2005 6, Dec. 6:40a Fortunata Sano /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore The Care Center @ Oakcrest Vill. Parkville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🛱 F 213-30-3882 Director 5-9-1929 Maryland Usual Residence of Decedent death with the Marylend 10a. State 10b. County 10c, City, Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or iteme 23a or 28e-f show traumatic event, the Medical Experiment must be notified at 1 ☐ Yes 2 XNo Director MD Parkville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 USA 8830 Walther Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after ☐Yes 2▼No 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 X No Specify: ğ 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home maker In own home 8th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi h and Mentai F 7 is marked ot Giovanni Sofia Carmela Pipito 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If item 27 is 7420 Green Bank Rd. Baltimore, MD 21220 Antoinette Brush 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 12/9/2005 Baltimore, MD permit. Page Department importent: If any injury or once. '4 □ Donation 5 ₺ Other (Specify) Entomb. Oaklawn 21. Signa ure of Funeral Service Licensee 22. Name and Address of Facility Joseph N. Zannino Jr. 263 S. Conkling St., Baltimore, MD 21224 Depte A annes art 1. Enter the disease, a emplications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. 23a art1. Enter the disease, Approximate Interval Between Onset and Death mediate Cause (Final disease or condition resulting in death) **Physician** ME UNIONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause, Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ng physician and as the burial-transit Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 ☐ Yes 2☐ No 2 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred After 1 Natural 5 🗀 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Hospitel or Attend within 24 hours after death To the Funeral Director; 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of certifier 29c. Livense number 29d. Date signed (Month, Day, Year) 0 30\_Name and address of person who completed cause of death (Item 23a) (Type, Print) BBUNGENR TUL 8 63 32 Registrar's Signature State 2005 Registrar

SANO

TOKTUNKT

2/6/05

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 15

		1 - For State Registrar	State of Maryla	nd / Depa	artment of F rtificate of	lealth and Death	Re	eg. No.	39322
Physici /Medic		1. Decedent's Name (First, Middle, Last,  Carl Vincent	Sterrett,	Jr.			2. Date of Deat Month Decembe	Day Ye	ar 2:06 A M
Examin		4a. Facility Name (If not institution, give Stella Maris Hos			4b. City, Town, o	r Location of Deat	h	4c. County of Death  Baltimore	
Funeral Director		216-48-0728	7. Age (In yr. 58	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. 1946	Birthplace (State or Foreigr Country) Maryland
anyland show	or	Usual Residence of Decedent  10a. State 10b. County  MD Balt		City, Town or Lo					10d. Inside City Limits
or 286-	Director	10e. Street and Number		Baltimor	10f. Zip Code		10	Og. Citizen of What	Country?
De tiele within 7 c nous after bean with the Maryland tial Hygiene. Ital Hygiene. do other than "natural", or itama 23a or 28e-f show svent, the Modical Exeminer must be notified at	by Funerai	6830 Sturbridge Dr  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1 Yes 2 No If Yes Give Year or Dates: 66 •		212 Was Decedent of H If Yes, specify Cub. 1□ Yes 2X No	lispanic Origin? (S	Specify Yes or No- to Rican, etc.)	USA  14. Race - A Black, W  Specify:	merican Indian, thite, etc. Black
Med within 72 ha Hygiene. Other than "natur ent, the Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of word d) andler	rking		ick & Compan
e e e >	To Be	17. Father's Name (First, Middle, Last)  Carl V. Sterrett,				Freida		d	
of Health and Ment of Health and Ment item 27 is marked rother treumatics		19a. Informant's Name/Relationship (Ty Christine Sterret	t/Wife	6830	Sturbrid	e Dr. A	ural Route Number,	timore, N	10 21234
Definit. Pages I Department of H Important: If ite any injury or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State Du	Laney V Morial	sition (Name of patory or other place alley Gardens	20	005	20c. Location - City Timonium	MD
Depart Import any inj		21. Signature of Funeral Service Libens:	el J. Flagle	Le 10	Name and Addre mmon Fundo: W. Pado:	ss of Facility eral Home nia Road	of Dula Timoniu	nev Valle	ev. Inc.
attending physician and area as the burial-transit for use as the burial-transit	edicai Examiner	disease or condition resulting in death)  Sequentially list conditions, and the sequentially list conditions, and the sequentially list conditions, and the sequential sequentia	Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.	equence of):	E CANCER				
y the attending pr	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3□	Ectopic pregnancy Other (specify)	,		23d. Date of o	delivery Day Year
been signed by the should be detached	þ	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.			lo the cause of death?  Probably 4 XUnknown
ate has	e Completed	25. Was case referred to medical						prior t ed? death No 1 □ Y	autopsy findings available o completion of cause of ? es 2□ No
this aldii	ation: To B	examiner?	lospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	er: 4 🗆 Nursing H	ath (Check only one one 5 Resider 28d. Describe how	nce 6 NOther (S	pecify) HOSPICE
. 0	Certific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre ify)	eet, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
within 24 hours aft To the Funerel DI completely filled in	edicai	29a. Certifier 1X Certifying Physical Control (Control one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, death nation and/or inv	occurred at the ting restigation, in my o	ne, date and place pinion, death occu	, and due to the car rred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
with To t	Σ	29b. Signature and tife of certifier	~		29c. Licens	13721	29	d. Date signed (Mo	nth, Day, Year)
19		30. Name and address of person who co				TIMONIUM	, MD 2109	03	
Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 6 2	32. Registrar's Sign	nature	Crarle 1				

DHMH 17 Rev 1/2001

		1 - For State Registrar	State of N	Maryland / Dep <i>Ce</i>	artment of I rtificate of			ene g. <b>2.</b> 0 0	5 39323
Physic /Med Exam	ical	Decedent's Name (First, Middle, I  Jean W. Schwin  4a. Facility Name (If not institution, g	ger	r)	4b. City, Town,	or Location of Death	2. Date of Death Month 11-29-	Day	Year 9:45 P
Funera		Lorian Mt.Airy  5. Social Security Number 6	Sex 7. A	Age (In yrs. last birthday,	Mt Airy If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day,		9. Birthplace (State or Foreig Country)
Director		219–140992 Usual Residence of Decedent	8	0 Trs.			12-11-1	921	Maryland  10d. Inside City Limits
the Marylar 28a-f show	Director	Md Howar  10e. Street and Number	rd	Glenwoo			10	g. Citizen of W	1 ☐ Yes 2 ☐ No
h with 23a or	ai Di	14119 Burntwood	s Road		21738			U.S.A.	
ING Z1Z13-UU30 be filed within 72 hours after death with the Maryland lal Hygiene. d other than "natural", or items 23a or 28a-f show event, Itel Medical Eran, nat must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1	5.00°	Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 No	Hispanic Origin? (Spe ban, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)	Black	- American Indian, , White, etc. White
Z I Z I D-UUJO d within 72 hours afi giene. sr than "natural", or the Medical Eratri	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		r 5+) (Give	DO NOT use retire	during most of worki ed)	ing	6b. Kind of Bus	,
filed w Hygier other th		12 17. Father's Name (First, Middle, La	st)	H	omemaker	18. Mother's Name	e (First, Middle, M.	Own Faiden Sumame	
land be lental rked o	To Be	Norris L. Uhle	r			Viola L	. Lucas		
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumetic event	1	19a. Informant's Name/Relationship				at and Number or Rura		-	
e, IV l and tealth im 27 her tr	1	Mr. Richard Sch	vinger (	Son) 141 20b. Place of Disp			-		cyland 21738 Dity or Town, State
<b>Saltimore,</b> permit, Pages 1 ar Department of Hez Important: If item any injury or othe	1	20a. Method of Disposition 1 Deburial 2 Cremation 3		cemetery, cre	matory or other pla	ace)			
<b>SAILIM</b> permit. Pag Department Important: any injury o		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie							le,Maryland
permit. Departimont any inj		b booph J.	1 00	100333 8	728 Liber	rty Road	Randalls	town, Ma	ryland 21133
		23a. P. v.11. Enter the disease, or co	omplications that caus	ed the death. Do not en		_			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		age Osteopo	rosis,Se	vere Osteo	arthriti	S	Onset and Death
/Medica Examine		resulting in death)	a	as a consequence of):					7-0-0-0
Examine		Sequentially list conditions,	b. Parkin	SON					
ed sit	nine	cause. Enter Underlying Cause (Disease or injury	Anemia	as a consequence on.					
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ate be executed assician and the burial-transit	cai Examiner		d. ==						
as light		In Ferring						_	
that the death certificated by the attending phy detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown		2 Fetal death 3 at time of death 5	□Ectopic pregnand □ Other (specify) _	cy		23d. Date Mon	of delivery th Day Year
HECONGS, P.O. he taw requires that the e has been signed by th tge 2 should be detache	by	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause g	iven in Part I.	23e. Did toba		bute to the cause of death? 3 ☐ Probably 4 ☐Unknown
The The ate h	Completed						24a. Was an autopsy perform	ed?) pr	fere autopsy findings available for to completion of cause of sath?
Or VIÇAL P Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		all post   0	26. Place of Death			- (0 % )
DIVISION OT  I or Attending Phys after death. Director: After this In by the funeral di	ation: To	1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Ir (Month, L		of 28c. Inju	4 K Nursing Ho	me 5 🗌 Resider 28d. Describe hov		
UIVISION OF To the Hospitel or Attending Physinia 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	3 Suicide 6 Could no 4 Homicide determin	ad 200. Place of	Injury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office	9	28f. Location (Stre City or Town,		r or Rural Route Number,
To the Hospitel or within 24 hours afte To the Funeral Dirc completely filled in I	edicai	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the be caminer: On the basis and manner	st of my knowledge, dea s of examination and/or is stated.	th occurred at the to nvestigation, in my	time, date and place, opinion, death occurr	and due to the cat red at the time, dat	use(s) and man te and place, a	iner as stated. nd due to the cause(s)
Toth within Toth	Me	29b. Signature and title of pertifier	Ru	lles W		158 number 54749	i	_	(Month, Day, Year) - 2005
2		30. Name and address of person w	4, MD_ 1	901 Toll Ho	Print)	e. D-1, FR	ederick	MD	- 2005 21701
S Regis	tate trar	31. Date filed (Month, Day, Year)	32. Regi	strar's Signature	frantes	,		,	
DHMH 17 Rev 1	6			State of the state					

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death December 02 Day 2005 Year **Physician** Margaret Κ. Shanklin 5:43 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Augsburg Lutheran Village Lochearn Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X**□ F 213-12-9744 84 Vre Director September 03,1921 Maryland Usual Residence of Decedent with the Manyland 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itams 23a or 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No Maryland **Baltimore** Baltimore Director 10e. Street and Number 10a. Citizen of What Country? 10f. Zip Code 6825 Campfield Road, Bldg #3E 21207 United States of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Home Maker & Special Educator 12 Ith and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if item 27 is marked c any intry or other traumatic eve once. Matthew Fitzgerald Edna Stuart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Shanklin (Spouse) 6825 Campfield Rd., Bldg 3E, Baltimore, M d. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lake View Memorial Pk 12/07/05 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sykesville, Maryland 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Name and Address of Facility Loring Byers Funeral Directors Inc Kollner Moo 333 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1, Inter the diserve, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CONCLETISE HEART WECK /Medical Due to (or as a consequence of) **Examiner** THEROSPLERETTE CAKDIOURSEJIAK Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to to for an a nonrequience off death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown NECCTON Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan rmed? 2 No 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending Injury investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) DSC. 5, 2005 DO075 844 30. Name and address of person who completed cluse of death (Item 23a) (Type, Print) OLD FREDERIPE CHLISTAS COMMERTERO, MO MA BALTAGRE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Gostal DEC 0 6 2005

Registrar

P.O.

Records,

of Vital

Division

SHANNON SCOTT SANDERSON

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			For State of Maryland / Department of Health and 1- State Unpend Item 23a,27,28a-f per mediate 2010 and to 1. Decedent's Name (First, Middle, Last)	as 2 Date of	Reg. N	_ U U U	3. Time of Death
	Physici		Shannon Scott Sanderson	Month NOV.		ay 2005	0426 A <sup>M</sup>
	/Medi Examir		4a. Facility Name (If not institution, give street and number) BALTIMORE WASHINGTON MEDICAL CENTER  4b. City, Town, or Location of 1 GLEN BURNIE			c. County of Dea ANNE AR	
	/					ANNE AR	UNDEL
0101	Funeral Director		218-13-8322 29 Yrs.	Min. 8. Date of (Month, 3-03-	Oav. Yea	r) 9. Bir Co M	thplace (State or Foreigr buntry) D
	land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	deeth with the Maryland me 23a or 28a-f ehow rmust be radified at	to	MD Anne Arundel Severn				1 ☐ Yes 23∑ No
	th the	Director	10e. Street and Number 10f. Zip Code		10g. C	itizen of What Co	ountry?
	ath wi	ral	8479 New Cut Road 21144			5.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important; if Item 27 ie marked other then "naturel", or Iteme 23a or 28a-1 show any injury or other traumatic event. Ite Mudical Exeminating the publical at once.	by Funeral I	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Forces?  1	n? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit Specify:	
Maryland 21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most o	function	16b.	Kind of Business	/Industry
215	ithin 7	Completed	(Specify only highest grade completed)  (Give kind of work done during most of life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)	Working	B B B B B B B B B B B B B B B B B B B		
7	iled w tygier her th	Co	4 Mechanical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's	Name (First, Mide	dle Maide	Plumb	ing
anc	d be fi	) Be		ia Darle			
<u> </u>	should nd Men marke	ပ္	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number of				Zip Code)
	alth a alth a 27 is		Cynthia D. Sanderson / mother 402 Kemper Road; J	oppa, MD	2108	35	
Baltimore,	es 1 a of He of He ritem		20a. Method of Disposition  1 ☐ Burial 2 IXCremation 3 ☐ Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c.	Location - City or	Town, State
Ë	Pag ment ant: i		4 □Donation 5 □Other (Specify) Chesapeake Cremation 1			evensvi.	
3alt	permit. Pag Department Important; I any injury o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility				ome, P.A.
	40 7 8 A		23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.			MD 2106	Approximate
68760,	ilicate be executed // Medical Examiner as the purial-transit as the purial-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Asthma complicated by Fentanyl In Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ntoxicati	on		Onset and Death
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O. Box	Attending Physicien: The law requires that the death cer r death. • ctor: After this certificete has been signed by the ettendin by the funeral director, page 2 should be deteched for use	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown   9   Unknown   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   2   Fetal death   5   Other (specify)   1   Live birth   1   Live bir			23d. Date of del Month	ivery Day Year
۵.	s that ned by e dete	y Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	- 23e. Di	d tobacco	use contribute to	the cause of death?
rds	equire en sig ould b	ed b		1[	Yes 2	2⊠No 3□Pr	obabły 4 Dunknown
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires within 24 hours after death.  To the Funaral Director: After this certificate has been signicompletely filled in by the funeral director, page 2 should be	Completed		pe	as an topsy informed?	prior to death?	itopsy findings available completion of cause of
Vita	iclan: sertific ector,	Be	examiner?	Death (Check on			
to	Phys r this ral dir	2	1 Inpatient 2 MEH/Outpatient 3 DOA 4 Nursi	ng Home 5 ☐ Re 28d. Describ			unk
0	ding th. Afte fune	tlor	27. Manner of Death  1 Natural 5 Pending (Month, Day Year) 2 Accident investigation  28a. Date of Injury 28b. Time of Found:  1 Natural 5 Pending investigation  1 Natural 5 Pending (Month, Day Year)  1 Natural 5 Pending investigation	İ		,	unk
Divisi	ei or Atter s after dea ni Director sd in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ★ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Found: Residence	28f. Location City or Severn	(Street a Fown, Star	nd Number of Pie 108479 Ne ne Arund	w Cut Road el County,
	Hospitel     24 hours     Funaral letely filled	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and part of the basis of examination and/or investigation, in my opinion, death and manner stated.	place, and due to the control occurred at the time	ne cause(: e, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and little of certified 29c. License number		29d. D	ate signed (Monti	h, Day, Year)
			O.C.M.E		NC	V. 30,	2005
1	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  111 PENN STREET, BALTIM	DE WYDV	Γ.ΔΝΤ	21201	and the first technique was
O		Ш	J. K. JUSTICO III PENN STREET, DALITM	ONL, PARL	עוואבשי	212UI	

State Registrar

32 Registrar's Signature

		State of Maryland / Department of Health and 1- State Registrar Certificate of Death	d Menta	al Hygien	000	39326
Physici		Decedent's Name (First, Middle, Last)  WALTER SCOTT		ite of Death onth Da	y Year	3. Time of Death 5:49 PM
/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Do  Franklin Square Hospital Rosedale	Death	40	Balt	more
Funeral Director		5. Social Security Number  6. Sex 1 M 2 F 7. Agel (In yrs. last birthday)  Yrs.  1 Months Days Hours N	Min. (M	te of Birth onth, Day, Year, 1–11–19	9. Bir 38	thplace (State or Foreign buntry) VA
show	ō	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits 1XX es 2 □ No
ith the Marylan or 28a-f show e notified at	Director	MD BALTIMORE ESSEX  10e. Street and Number 10f. Zip Code		10g. C	tizen of What Co	ountry?
e 23a	eral [	1 EASTERN BLVD. 21221  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	2 (Specify V	on or No	USA 14. Race - Ame	arican Indian
ie, ividity idilid ZIZIS-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Health and Mental Hygene. Item 27 is marked other than "natural; or iteme 23a or 28a-f show other traumatic event. If a Me Jicki Era in an orallized and other traumatic event. If a Me Jicki Era in a matter matter notified at	by Funeral	11. Marital Status  1	Puerto Rican,	etc.)	Black, Whi	
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ild CICI a filed within if Hygiene. other than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  12 ORDERLY		м	) GENERA	AL HOSPITAL
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should be nd Mental marked o	L <sub>O</sub>	WALTER SCOTT  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	OTHY FO		or Town State	Zio Code)
and 2 sho ealth and in 27 is mu		JOSEPH SCOTT/BROTHER 12128 EASTERN AVENU		LTIMORE		1220
Dallillore, in permit. Pages 1 and Department of Health Important: If item 27 any injury or other trong.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date		ocation - City or	
dilling mit. Pages partment of portant: If it y injury or o		'4 Donation 5 Other (Specify) HOLLY HILL MEM. GRDN.	12-7-	-	DLE RIVI	ER, MD ONS F.H., INC.
Daliti permit. Departr Importe any inju		James G. Morton 1701-31 LAURENS		BALTIMOI		21217
Physician JMedical Examiner and popularitansit	al Examiner	23a. Part Anter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	CA	natory arrest,		Approximate Interval Between Onset and Death
that the death certificate be executed that the death certificate be executed of by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1			23d. Date of de Month	livery Day Year
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VICAL INCO eician: The law rec s certificate has bee lirector, page 2 shot	Completed		-	4a. Was an autopsy performed? ☐ Yes 2 No	prior to death?	utopsy findings available completion of cause of
OI VIIdi ne Physician: The la r this certificate hav iral director, page 2	Be	25. Was case referred to medical campiner?  Hospital: Cherry Control C				
a the	tlon: To	27. Manner of Death 1 North, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 1 North, Day Year)	28d. D	i □ Residence rescribe how inju		cify)
LIVISION  Lor Attending after death. Director: After	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		ocation (Street a. ity or Town, Stat		ural Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After dompletely filled in by the funeral completely fi	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pl 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 3 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 3 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 3 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 3 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 3 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 3 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and pl 3 medical Examiner: On the basis of examination and/or investigation.				
To the within 2	Me	29b. Signature and title of certifier  29c. License number  D 5 4 7 3 5		12	ate signed (Mon	
HI		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Tosic Lopez 900 Franklin Square Drive, Bo  31. Date filed (Month, Day, Year)  DEC 0 6 2085	11.		1) 21-	) > -7
Sta	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	altin	1016 1	1) 210	<del>+</del> <b>3</b> <i>1</i>
Regist		DEC 0 6 2085				

			1 - For State Registrar	State of Marylar		artment of <i>tificate o</i>		id Me		jiepe) () 5 eg. No.	3932	7
Ī	Physici /Medic		Decedent's Name (First, Middle, Last,     ANN CARR SCOTT						Date of Dea Month Pecembe	Day	3. Time of D 05 6:54	
<b>&gt;</b>	Examin		4a. Facility Name (If not institution, give 19A Mopec Circle			Balt	, or Location of C imore				imore	
1.2	Funeral Director			7. Age (In yrs. 75	last birthday) Yrs.	If Under 1 Year Months Day		Hrs. 8. Min.	Date of Birth (Month, Day June 20	, 1930	9. Birthplace (State or Country) Maryland	Foreign
	e Maryland 3a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimore		ty, Town or Lo	cation					10d. Inside City 1 ☐ Yes 2	
	23a or 21	ai Dire	19A Mopec Circle			10f. Zip Code 212			1	0g. Citizen of Wh		
920	urs after dea bi', or Items xammer m	by Funeral Director	11. Maritaf Status  1 Never Married 2 Married  3 Widowed 4 X vivorced	12. Was Decedent Ever in U Armed Forcas? 1 ☐ Yes AN No It Yes, Give Year or Dates:	i i	Was Decedent of Yes, specify C	f Hispanic Origin uban, Mexican, F io <i>Specify:</i>	? (Specifi Puerto Ric	y Yes or No- an, etc.)		American Indian, White, etc.	
21215-003	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any figury or other traumatic event. The Medical Examinar must be notified at ODGs.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) Colfege (1-4or 5+)	(Give	OO NOT use reti	e during most of			16b. Kind of Busi	ness/Industry	
Maryland 2	ild be filed lental Hygi ked other ilc event. I	To Be Co	17. Father's Name (First, Middle, Last) William Lantz Scot	tt	1		18. Mother's	Name (F	irst, Middle, I	Maiden Sumame)		
Mary	ind 2 shou alth and M 27 is mai		19a. Informant's Name/Relationship (Ty Roy G Hatch	ype, Print) Son						; City or Town, St Iryland 2		
altimore,	Pages 1 a Iment of He tant: If Itam jury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ X remation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Gre	eenMoun	sition (Name of natory or other p t Cemet	ery 12	Date 2/5/0	5		re, Marylar	
Ba	Departiment important in any in conce.		2) Fignature of Funeral Server Licens	en Kenaki	12	6500	York Roa	ad Ba	ltimor	e, Maryl	I Funeral H and 21212	lome
	Physician and street be executed by hysician and street st	Examiner	23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	uence of):	ar the mode of o	ying, such as cal	rulac or re	sspiratory arm	951,	Approximate Interval Between OnSet and De	
, P.O. Box 68760	The law requires that the death certificate be sie has been signed by the attending physicis agge 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	d	aldeath 3 death 5 death	Ectopic pregnar Other (specify)			23e. Did tob	23d. Date (Month		
Division of Vital Records,	The law requires sete has been sign page 2 should be	Completed by							1 Yes 24a. Was an autops perform	n 24b. We y prio	Probably 4 Universe autopsy findings avor to completion of cauth?	/ailabfe
Ital		ВеС	25. Was case referred to medical examiner?					Death (C	hack only on			
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DIVIS	To the Hospital or Attend within 24 hours after death To the Funeral Director: / completely filled in by the t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, offic	ө	28f.	Location (St. City or Town		or Rural Route Numbe	3 <i>r</i> ,
	Mospita 24 hours Funeral etely filled	ledical	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	rsicien: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and p opinion, death of	place, and occurred a	due to the ca at the time, da	ause(s) and mann ate and place, and	er as stated. d due to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 9	/ ^^	29c. Lice	nse number	21	25	9d. Date signed (i	Month, Dey, Year)	
1	X		30. Name and address of person who	ompleted cause of death (Item	1 23a) (Type	Print) =	) 721	16	0	ecembe	75,20	05
1	<b>D</b>		Thomas J. Lyn	nch, MD.	301	St. R	1 B	Balt	imor	e, MD	2120	12
1	Sta Registr	_	31. Date filed (Month, Day, Year)  DEC 0 6 2	32. Ro strar's Signa	A A	pack				-		

State of Maryland / Department of Health and Mental Hygiene | | 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** DORIS NOAMA SMITH December 4, 2005 9:41 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City UNION MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Days **Funeral** Hours 1 ☐ M 2 🖳 F 88 214-74-3466 Director Mar 8, 1917 Maryland | Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 'natural', or Iteme 23a or 28e-f show traumatic event, the Mudical Examinar must be notified at 1 1 Yes 2 □ No Directo Marvland Baltimore City N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 1040 Deer Ridge Drive, #302 <u> 21210</u> USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A unknown permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Importent: If Item 27 is marked oth any injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Daniel Lewis Smith <u>Ann Holt Pritchard</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 204 East Joppa Road, #PH7, Towson, Maryland 21204 (Sister) Evelyn E. Mitchell 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Green Mount Cemetery 12/6/2005 Baltimore, Maryland 21. Signatu e of Funeral Service Licenses 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MS **Physician** /Medical Due to (or as a consequence of): Examiner Hyneslèrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed by the attending physicien and tached for use as the burial-transit SCID that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month signed by the at d be detached for 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0004701 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Court nd S. MALINDUS 3635 21208 32. Redstrar's Signature 31. Date filed (Month, Day, Year) 2005 Registrar DEC 0

			1 - For State Registrar		of Marylai			nt of H				Reg. No		393	29
)	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle LOUIS Rate of Institution of Ins	OBERT	10.1	man	4b. Cit	y, Town, or	Location of	of Death	2. Date of D Month Decemb	PT 40	Year L 200 C County of De	5 11:2	of Death
>· .	Funeral Director		5. Social Security Number 219–14–0425  Usual Residence of Decedent	6. Sex	7. Age (In yrs <b>84</b>	. last birthday) Yrs.	Month:	er 1 Year S Days	If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D 09/15/	irth ay Year <b>1921</b>	9. B	rthplace (State Country)	or Foreign
	the Maryland r 286-f ehow retilies at	Director	MD BAL  10e. Street and Number	TIMORE		BALTIM	ORE	ip Code				10a. Ci	tizen of What (	10d. Inside	_
21215-0036	be filed within 72 hours after deeth with the Maryland hat Hyglene. d other then "neture!", or iteme 23a or 28e-f ehow event, the Medical Exeminar must be notified at	by Funeral	3215 SMITH A  11. Marital Status  1 Never Married 2 M Ma 3 Widowed 4 Divorce  (Specify only high	12. Was Dec Armed F rned 1 (YYes	2 No ive Dates:	16a. Dece	Was Dec If Yes, sp 1 ☐ Yes	21208 redent of Hi becify Cuba 2 X No	Specify:		ecify Yes or N Rican, etc.)	U.S	.A. 14. Race - Am Black, Wh	erican Indian, ite, etc.	
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	ges 1 and 2 1 of Health If Item 27 or other tr		GRETA SHULMAN  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation	•		Place of Dispo	osition (N	ame of			LTIMOR Date		ID 21208 ocation - City o		
Baltimore,	permit. Pag Depertment Important: I eny Injury o		4 Donation 5 □ Other (21. Signature of Juneral Service	Specify)	TWO	ESMOSR <sup>2</sup>	HEB 2. Name	EW and Addres					<b>TIMORE,</b> & BROS		
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sion of \	Phys this aldii	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pend 2 Accident inves	Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5					ne 5 Resi			ecify)			
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or generalization	sk.	1. Decedent's Name (First, Middle, La	st)							2. Date of Dear	th Day	Year	3. Time of	f Death
Physicia /Medica		Victoria Lynn T	lucci							NOVEMBER		2005	1340	РМ
Examine		4a. Facility Name (If not institution, given 707 E. PATASCO AV		ber)		BALT	IMORI					nty of Death	1	
Funeral Director		5. Social Security Number 6. S  216-44-5367  Usual Residence of Decedent	Sex 7 □M 2√√ F	7. Age (In yrs. 51	**	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day) Jan 21,		Col	nplace (State of untry) yland	or Foreigi
nand ow	1	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside C	ity Limits
the Marylan 28a-f ehow	to	MD		Ва	ltimor	e							1 ∏ Yes	2 🗆 No
ire, Maryland 21215-UU36 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mentai Hygiene. Item 27 is marked other then "natural", or iteme 23s or 28s-f show other traumatic event, the Medical Examiner must be notilised at	Funeral Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Co	untry?	
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ome	Iner	11. Marital Status	12. Was Deced	tent Ever in U	I.S. 13.	Was Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No- Rican, etc.)		Race - Amer Black, White		
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Physician		shock or heart failure. List only Immediate Cause (Final			natia C	'andia			Di -				Interval Bet Onset and	
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the hin 2 ths 1	Med	one)	and mann	er stated.										
To To Com		29b. Signature and title of certifier	. mid			290	: Licensi	number ME					, Day, Year) , 2005	
2		1.0	, ruce										, 2007	
		30. Name and address of person who		of death (Ite			MINT C'	יייםים סיו	1D A	T TTMODE	MATIN	רד א אדר	21201	
		31. Date filed (Month, Day, Year)	mil	alatas de Ot		II LU	TATA D	TVEET	, BA	LTIMORE,	, MAKY	LAND,	Z1Z01	
Stat	te	DEC 0 6	32. He	igistrar's Sign	aluie	and i	_							

Amend item#5, per Inf. G850, 12,115,005 TI State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CYNTHIA Day **Physician** THORNTON Month Year 11-00 PM OVEMBER 24 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 2826 WINCHESTER STREET BALTIMORE NA If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Socurity Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 ☐ M 2 🗷 F 213.53.3677 51 10.28.1948 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. toside City Limits Funeral Director NA 1 Yes 2 No MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? STREET 2826 WINCHESTER 21216 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 ☑ No þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COORDINATOR 12 TH GRADE SOLO CUP COMPANY NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LLOYD T. KNOX MARY HORSHAW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2826 WINCHESTER ST. FREDDIE THORNTON, SK BALTO. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. ZION 12.03.05 BALTIMORE 21. Signature of Funeral Service Dicensee 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 5151 BALTO. NATU PIKE, BALTO. MD 21229 Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) arcinoma rasta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine resulting in death) Last Due to (or as a consequence of) Physiclan/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 □Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 \_ tnpatient 2 \_ ER/Outpatient 3 \_ DOA 1 ☐ Yes 2 XNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 Naturat 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

hours after death.

nerel Director: After this filled in by the funeral di Division within 24 hours a To the Funerel I completely filled Hospitel

**Funeral** 

Director

Item 27 is marked other then "naturel", or iteme 23s or 28s-f show other traumatic event, the Mcdcal Examinar rough be notified at

within 72 hours after

Pages 1 and 2 should be fil ment of Health and Mental H lent: If Item 27 is marked otl

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Department of importent: If eny injury or once.

**Physician** 

The law requires that the deeth certificate be executed

Box 68760

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of Vital

/Medical Examiner

attending physicien and for use es the burial-transit

signed by the a

certificete hes birector, page 2 s

this

director,

Baltimore, Maryland 21215-0036

State Registrar

SAMBANDAY 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BAS KARAN

2005

WILKENSIAVE BALTIMORE MOZIZZA 32. Registrar's Signature

021649

29d. Date signed (Month, Day, Year)

NOVEMBER 30, 2005

OTIS THORNTON 05-08154 RKD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar	State of Ma	aryland		artmen rtificate					Reg. No	~ ~	5	3933	2
	Physici	an	Decedent's Name (First, Middle, L	ast)							2. Date of De Month DECEMB	ath Da	y 0.5	Year	3. Time of D	eath
	/Medic Examir	cal	OTIS  4a. Facility Name (If not institution, gr GOOD SAMARITAN He	ive street and number)	NTON			Town, or	Location o	of Death	DECEMB			O5 of Death	3:40P.	М
	Funeral Director		5. Social Security Number 6. 241-20-7356 Usual Residence of Decedent	Sex 7. Ag	e (In yrs. Ia:	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Date of Bird)			9. Birth Cou	place (State or I	Foreign
	th with the Maryland 23s or 28s-f show	Director	10a. State 10b. County MD			Town or Lo	ORE								10d. Inside City 1 ☐ Yes 2	
	with t	ä	10e. Street and Number				10f. Zip					10g. Ci	tizen of V	What Cou	ntry?	
9003	hours after des turel', or Items al Examiner m	ed by Funeral	4722 WRENWOOD AV  11. Marital Status  1 Never Married 2 Married  35 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 TYes 2 1 If Yes, Give Year or Dates:		1	1□Yes 2	lent of Hi offy Cuba 2 No	Specify:		ecify Yes or No Rican, etc.)	-	Specify	k, White,	ACK	
Maryland 21215-0036	within ene. then	Completed	15. Decedent's Elementary/Secondary (0-12)	College (1-4or 5		(Give	dent's Usua kind of wor DO NOT us	rk done d	luring mos	t of worki	ng			usiness/lr	dustry	
מס	be filed htal Hygi od other	4	17. Father's Name (First, Middle, Las	st)		LADUK	CK		18. Mothe	er's Name	(First, Middle,		STEE Sumam		·	
ylar	2 2 2 3	To B	WILLIAM PLUMBER						C	ORA	JONES					
Mar	d 2 shou th and M ?7 is mark traumati		19a. Informant's Name/Relationship OTIS M. THORNTO			19b. Mailir					Route Numbe					
	1 an Heal Heal		20a. Method of Disposition	N, JR/SUN	20b. Pla	ce of Dispo	sition (Nam	ne of			ROAD/BA				21212 own, State	
Baltimore,	permit. Pages Depertment of I Important: If it eny injury or o		1 Durial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	ify)	cen	RISON	FORES	ST V	.A.	12/0	9/05	OWI	NGS 1	MILL	S, MD	
Bal	Depermine trapo		21. Signature of Funeral Service Lice  23a. Papt. Enter the disease, or con-	Morto	71			LAUR1	ENS S	TREE	T, BALT	0.,			NS .F.H	, IN
8760,	Physician /Medical Examiner physicien end ph	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	a conseque a conseque	nce of):	ferci	DI	sea	Ca se	vdieva	SCis	Qa ;	)	Onset and De	ath
P.O. Box 6	death certific e ettending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal d	eath 3□	Ectopic pre						23d. Date Mor	e of delive	ery Day Yea	ar.
Records, P	The law requires that the site has been signed by the bege 2 should be detache	þ	Part II. Other significant conditions END Stage Veil	contributing to death be		ing in the ur	nderlying ca	ause give	n in Part I.		1	obacco i		ibute to the	ne cause of dea	
		Completed											P	rior to co leath?	psy findings ava mpletion of cause 2 No	
₹	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1    Yes 2   No	Hospital:	nt 2DTF	R/Outpatien	t 3 DO	Δ Othe			<i>(Check only o</i> ne 5 ☐ Resid		c 🗆 🗆	(0		
Division of Vital	Afte Tune		27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		8b. Time of Injury		Bc. Injury Work		2	28d. Describe h				<u> </u>	
Divis	Ital or Attend its after death rel Director: led in by the i	Certification:	3 Suicide 6 Could not 4 Homicide determined		ury - At hom c. <i>(Specify)</i>	e, farm, stre	eet, factory,	, office		4	28f. Location (5 City or Tow	Street an In, State	nd Numbe	er or Rura	l Route Numbe	r,
	To the Hospital within 24 hours a To the Funeral is completely filled	Medicai	one) 2X Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examinatio	edge, death n and/or inv	estigation,	in my op	inion, deal	d place, a th occurre	ed at the time, o	date and	d place, a	and due to	the cause(s)	
	To To		29b. Signature and title of certifier	10.0		a	29c.	License				29d. Da	te signed	(Month,	Day, Year)	
,	1		30. Name and address of person who	Malla l	auth (Item 2	30) (Tuna	Print'	0.0	.M.E.			DECE	MBER	4,	2005	
H	,		CAROL H 7	TLLAN	M.	oa, (τypθ,		PENN	STRE	ETT F	BALTIMOE	RE M	ARYT.	AND	21201	
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			1 - For Stete Registrar	State of Mar	yland /		tment ificate				Reg	2°005	39333
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Alice Tyler								Date of Death Month OVEMbe	r 27 20	3. Time of Death 1435 M
	Examin	er	4a. Facility Name (If not institution, give s Anne Arundel Med	ŕ	ter	4			ocation of D	Death		4c. County of D	eath Arundel
i i	Funeral Director		5. Social Security Number 6. Sex 577 – 32 – 3971		in yrs. last bi		If Under 1 Vonths	Year Days	If Under 24 Hours	Min.	Oate of Birth (Month, Day, 1		Birthplace (State or Foreign Country) Lryland
	Maryland	to l	Usual Residence of Decedent  10a. State  10b. County  Maryland Anne Ar		Oc. City, Tow Lot	n or Local hian							10d. Inside City Limits 1 ☐ Yes 2 No
	th with the 23a or 28a	Funeral Director	10e. Street and Number 1038 Bayard Rd.				10f. Zip C	)711			100	J. Citizen of What USA	Country?
0500-0	ours after dea ai', or iteme Examiner mi	by	11. Marital Status  1 Never Married  Married  3 Widowed 4 Divorced	Was Decedent Event Armed Forces?     Marcology       Marcology       Marcology       Marcology       Marcology       Marcology       Marcology       Marcology       Marcology	er in U.S.		s Decede es, specif		panic Origin Mexican, P Specify:	i? (Specify Puerto Rica	Yes or No- in, etc.)	14. Race - A Black, W Specify:	
N-C1717	is 1 and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene.  If the ath and Mental Hygiene.  If marked other than "natural", or iteme 23a or 28a-f ehow other traumatic event, the Marchal Examinar must be publised at	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 5th	cation completed)  College (1-4or 5+)	16a	Deceden (Give kin life. DO	nd of work NOT use	Occupat done du retired)	ion ring most of	f working	C	arr Bro estaura	others
yland	ould be file Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last)  James Samuel Ha						Mary	Ann	Doug1		
Mar	and 2 sh alth and 127 is m er traum		19a. Informant's Name/Relationship ( <i>Typ</i> James Wallace(S	· ·								City or Town, State	
allimore	permit. Pages t and Department of Heali important: if item 2 any injury or other once.		20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)		20b. Place of cemete Mose:	ry, cremat	tory or oth	er place)	12	Date 2-3-0		ury, Mo	
Dall	permit. Departr importr any inj		21. Signature of Funeral Service Licenses		3	22. N Wm 82	lame and Re 1 We	Address ese	of Eacility Sc	ons N Annar	Mortua oolis,	ry, P. A	A. 1401
	hysician /Medical		23a. Part1. Enter the disease, in complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the cause on each line.  Thhoco  Due to (or as a common of the comm	aneal	Remo	the mode	of dying,					Approximate Interval Between Onset and Death Chrs
200	xate be executed  x x   bysicien and  the buriat-transit	ical Examiner	Sequentially list conditions, if any, learning to limited accuses. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c									
.O. DOX 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 bours after death.  Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	c. If yes, outcome of 1 Live birth 2 [ 4 Pregnant at tim 9 Unknown	Fetal death		ctopic preg ther (spec					23d. Date of o	delivery Day Year
ecolus, r	en signed bould be deta	þ	Part II. Other significant conditions cont Diabeta Me	Miles	not resulting i	n the unde	erlying cau	ise given	in Part I.		23e. Did toba	1	to the cause of death?  Probably 4 □Unknown
מו שפכנ	To the Hospital or Attending Physician: The law is white 24 hours after death. The law is 4 the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 should be a second to the funeral director, bage 2 should be a second to the funeral director.	Completed									24a. Was an autopsy performe 1 🗆 Yes 2 🖺	d2 prior t	autopsy findings available o completion of cause of ? es 2 □ No
o vitai	hysicial	To Be	1 163 2 2 140	ospital:	2 <b>⊠</b> ER/Oι		3 DOA	Other			eck only one) 5 □ Residend	e 6 □Other (S	oecify)
	eath. or; After Ithe funera	Certification:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28a. Date of Injury (Month, Day Y	ear) 28b.	Time of Injury	M 280	Mork? Ugry a Ugry a Ugry a	t s 2 □No	28d.	Describe how	injury occurred	
2	oltal or Att urs after d ral Direct		4 Homicide determined	28e. Place of Injury building, etc. (	Specify)						City or Town, S	State)	Rural Route Number,
	the Host in 24 ho the Fune pletely f	edical	29a. Certifier (Check only one) (Check only one)	er: On the bast of ex and manner stated	amination an	e, death od id/or inves	curred at tigation, in	the time, n my opin	date and pl ion, death o	lace, and o	the time, date	se(s) and manner and place, and d	as stated. ue to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	Burkey	- 1/14	0		License r				Date signed (Mo	nth, Day, Year)
	3		30. Name and address of person who cor	npleted cause of deat	h (Item 23a)	(Type, Prin	nt) .		763			nem oct c	x - , 200-
200	Sta		31. Date filed (Month, Day, Year)	32. Registrar's		الاهام	999,	VV 02	21 0/1,1	01)	עייי		
	Registr	ar	DEC 0 6 2005	A Partie Land	K A	234	5	•					

State Registrar 31. Date filed (Month, Day, Year)

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2005 6

rar's Signature

111 PENN STREET, BALTIMORE, MARYLAND, 21201

State of Maryland / Department of Health and Mental Hygiene 15 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:13 a<sup>M</sup> Abraham Wood December 3,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Greater Baltimore Medical Center 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-09-1915 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Yrs. South Carolina Director 247-26-1527 89 Usual Residence of Decedent 10a. State 10b Counts 10c. City, Town or Location 10d. Inside City Limits Iteme 23a or 28a-f show 1X Yes 2 □ No Director MD NA **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1401 N. Dukeland Street 21216 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 5 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Giest Wood Emericus Linder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau Boniette D. Wood / Wife 1401 N. Dukelnad St. Balto, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-08-05 King Memorial Park Randallstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility mas Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASYSTOLIC CORPIAC ACREST **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Medical Certification; To Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed Box 68760/ Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? OBSTRUCTION 1 Yes 2 No 3 Probably 4 Onknown REWAL PHEASE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No performed? 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral. 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 12 Certifying Phynician: To the best of my knowledge, death occurred at the time, date and place, and due to the daese(s) and mainter as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 6569 N.Chales 31. Date filed (Month, Day, Year) 32. Registrar's Signature

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State

Registrar

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State of Maryland / Department of Health and Mental Hygien = 0.5Certificate of Death

3. Time of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 5:15 PM EUGENE DOUGLAS WHITE NOV 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SAINT AGNES HEALTH CARE NA BALTIMORE, MD 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Days Hours 100 M 20 F MD 10.07.1958 Director 214.70.9713 Usual Residence of Decedent 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits show na 23e or 28a-f shov 1 **2** Yes 2 □ No BALTIMORE NA MD Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 136 DENISON STREET USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours af Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or any julury or other traumetic event, the Mucical Examp. Once. 1 ☐ Yes 2 🛛 No Specify: Specify: BLACK Completed by 3 X Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MILITARY 12 TH GRADE NA SOILDER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ADLENER JAMES CHARLES LEWIS WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ADLENER ANDERSON (MOTHER) 4406 ELDON RD BALTIMORE MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from State 12.08.05 OWINGS MIUS. GARRISON FOREST \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furneral Service Licenses 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE austr 5151 BALTO. NATE PIKE, BALTO. MD 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE LIVER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dire to (or as a consequence of): Examiner it any, leading to him ediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy in the past 12 months? Dav 4□Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No Completed 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ths Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asmin Ali Hamigani, 1751O NOVEMBER, 30, 2005 Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. YASMIN ALI HAMIRANI, 900 CATON AVENUE, BALTIMORE, MD, 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001 ORIGINAL

within 24 hours e c mpletely

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 30, 2005 30. Name and addr cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature DEC 0 6 2005 **ORIGINAL** 

State

Registrar

State of Maryland / Department of Health and Mental Hygiene 39339 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Year Dec 3, 2005 10:06 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth
Dec 30, 1921 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 83 Director 065 14 5293 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Itams 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes ½ √2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4554 C. Ryan Place 20602 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after 1 □ Yes X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2No Specify: ð White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other then ", eny injury or other traumatic event. In a Mag Quice. Elementary/Secondary (0-12) College (1-4or 5+) Medical Secretary Hospitals 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bejamin Postman Wilma (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4554 C. Ryan Place, Waldorf, MD Merle Whitt (Husband) 20602 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dec 6, 2005 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington National Cemetery Suitland, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Rd, Clinton, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACUTE MYOCAR DIAL INFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-t Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) o. 1 Yes 2 No 9 Unknown 9 Unknown ۵ should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ DIABETES MECLITUS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed CONSESTIVE HEART FAILURE 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: / 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct completely filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dogur D40374 DECEMBER 3,2005 0 30. Name and vidress of person who completed cause of death (Item 23a) (Type, Print) JODRIE, MID. 7503 SURRATTS ROAD, CLINTON, MAKYLAND 20735 31. Date filed (Month, Day, Year) 32. Registrar's Signature\_ State Registrar

			1 - State Registrar	State of Marylan		rtment of H tificate of		d Mental Hy	giene	05	39340	
	Physicia /Medic		1. Decedent's Name (First, Middle, Last	, D		W:1	SOA	2. Date of De Month	aath Day	Year 4, 2005	3. Time of Death	М
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	with the a or 24		10e. Street and Number			10f. Zip Code				n of What Cour	ntry?	
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1	7		30. Name and address of person who co	and manner stated.  M. J.  completed cause of death (Item  600 Worth  32. Alegistrar's Signa	23a) (Type. I	KE Print)	5-00	0	Dece	mber	4,2005	-
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			State Registrar		C	ertificate of	Death	R	eg. No.			
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100. 140.			(R.G.RUTH) RUCK TOWSON FUNERAL HOME, INC. TOWSON, MI  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
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	10		30. Name and address of person who	completed cause of de	ath (Item 23a) (Ty	rpe, Print)				1		
	TU		David P Boersm			Osler :	Dr Tou	USUA M	19 3130	04		
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State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 5

	,		For State Registrar	State of Mary		artment of F rtificate of			tm 0 0 0	39342
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The same	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death	1	4c. County of Dea	ith
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	or 28	Director	10e. Street and Number	0:- 0:	-1111	10f. Zip Code		1	0g. Citizen of What C	•
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	4		30. Name and address of person who co			Print) M(57	CEA TO	202	1.00	147 7 1177
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	Director		499-22-0253	344 000	77	Yrs. Mont	hs Days	Hours M	lin. 8. Date of Birth (Month, Day 2/22/19	28 Mis	irthplace (State or Foreign Country) SSOURI
	pu &		Usual Residence of Decedent  10a, State 10b, County		10c. City, Tow	m or Location					
	Aaryla f eho	ō	Virginia Accomad	2	•	ncoteaq	nie				10d. Inside City Limits 1X Yes 2 □ No
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	h with	DIE	7257 Olga Drive				2333	36		USA	
	within 72 hours after death with the Maryland ene. then "neturel", or leme 23e or 28e-f ehow the Madical Exertirat must be notilled at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was De	ecedent of His	spanic Origin?	(Specify Yes or No- lerto Rican, etc.)		nerican Indian,
36	or it	by Fu	1 Never Married 2 Married	1 → Yes 2 □ N If Yes, Give A Year or Dates:	o vir Ford	1 ☐ Yes	s 2 <b>X</b> No	Specify:	rono moun, etc.,	Black, Wh	white
21215-0036	hour fure!	ed b	3 Widowed 4 Divorced  15. Decedent's Edu			. Decedent's U	Isual Ossupa	tion			
75	on 72	piet	(Specify only highest grade Elementary/Secondary (0-12)	e completed)		(Give kind of		uring most of v	working	16b. Kind of Busines	sylnoustry
213	d with	Completed	12	College (1-4or 5-	+)	Person	nel			Governm	ent
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental hygiene. Item 23 is marked other then "nature!", or iteme 23a or 28a-f show other treumatic event, the Madical Exercities must be notilled at	Be (	17. Father's Name (First, Middle, Last)						Name (First, Middle,	,	
Z	should nd Men marke umatic	P.	Frank Aldridge						dia Willhi		
Maryland	d 2 sho th and the m 7 ie m treum		19a. Informant's Name/Relationship (Ty Connie Aldridge/v	•	196				Rural Route Number		
	Health tem 27 other tr		20a. Method of Disposition	,TTG	20b. Place o	f Disposition (	Name of	I	ncoteague,	VA 23336 20c. Location - City of	
altimore,	permit. Pages 1 en Department of Heal Important: if Item 2 any injury or other ance.		1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Qonation 5 ☐ Other (Specify)		cemete	ry, crematory c sbury C	or other place			Salisbur	
=	Darter Poorter		21. Ignalitie of Funeral Service Lices			_					
ä	Depa Impo any is		with the	6		501	Snow 1	runeral Hill Ro	Home Pro B., Salisb	iessional urv, MD 2]	Association
			3a. Part. Enter the disease, or compli- shock, or heart failure. List only or	ications at caused in	the death. Do						Approximate Interval Between
	Physician	8 9	Immediate Cause (Final disease or condition	Right	+ hear	of Fa	Jun	e_			Onset and Death
	/Medical Examiner		resulting in death)	Due to as a	consequence						
		- G	Sequentially list conditions,	Due to (or as a	consequence	of)·					years
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Lieuse or injury that initiated events	2 2 2 1 2 (3. 4.0 2		5.7.					1
ó	exection and and rial-tra	Exa	resulting in death) Last	Due to (or as a	consequence	of):					
8760,	icate be executed physicien and the burial-transit	dical		t							
9	entifica ling ph	Med	IF FEMALE:			_					
Вох	The law requires thet the deeth certific lie has been signed by the attending pi page 2 should be detached for use as f	Physician/Me	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1□Live birth 2	2 ☐ Fetal death		pregnancy			23d. Date of d	elivery Day Year
P. 0.	the de	ysic	1 Yes 2 No	4☐ Pregnant at t 9☐ Unknown	ime of death	5 Cother	(specify)				Day Tour
	es thet thighed by be detact	by Ph	Part II. Other significant conditions cor	ntributing to death bu	t not resulting in	n the underlyin	g cause givei	n in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
Division of Vital Records,	quires on sign	q pa							1)X Y6	s 2 □No 3 □ F	Probably 4 Unknown
S	law requir as been si 2 should	Completed							24a. Was a		autopsy findings available
ž	The lay ate has page 2	mo:							- autops perform 1 Yes 2	ned? death?	completion of cause of
/ita	ysician: The lis certificate he director, page	Bec	25. Was case referred to medical examiner?	-				26. Place of D	eath Check only on		3 200110
5	Physician: this certific ral director.	2	1 ☐ Yes 2 No	fospital:			DOA Other	4   Nursing	Home 5 ☐ Reside	nce 6 Other (Sp	ecify)
S N	ling F After funera	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	/ 28b. 1 Year) 1	rime of njury	28c. Injury Work		28d. Describe ho	w injury occurred	
isi	deeth ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injur	ny - At home, fa	M rm street fact		es 2 No	28f Location (St	reet and Number or F	Pural Cauta Mumbas
<u>≥</u>	after after Dire	Certification:	4 Homicide determined	building, etc.	(Specify)	im, street, race	lory, onice		City or Town	, State)	turai Houte Number,
	To the Hospital or Attending Phwithin 24 hours atter deeth. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier  12 Certifying Physical Examin	sician: To the best of	f my knowledge	daath conum	ed at the time	data and pla	ce, and due to the ea	iuse(s) and manner s	is stated.
	the H nin 24 the F pplete	Medical	51.0,	ner: On the basis of and manner state	ed.	d/or investigati	ion, in my api	nion, death oc	curred at the time, da	ate and place, and du	e to the cause(s)
	S S S S S	2	29b. Signature and title of certifier	0		1	29c. License		I .	od. Date signed (Mor	* '
•	43		Davidk	eden	MD		500	626	70	11/10-105	
	7,2		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (	(Type, Print)	79 11	26 C.	1/61 (	1.1.	MD 21801
	Sta	te	31. Date filed (Month, Day, Year)	32. Hamistrai	r's Signature			VE. CW	1011 51,	salicbury,	IND VIBOI
	Registr		MOA T 8 51	005	u. H.	Boach	0				

Longie Aldridge

			For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of tificate of	Health a Death	and M		iene) (	)5	393	44
	Physici	an	1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month	h Day	Yeer	3. Time o	
	/Medic		James	Badget	t				11	11	05_	8:36	Рм
	Examir	er	4a. Facility Name (If not institution, give : Union_Hospital	street and number)		4b. City, Town, E1kto		of Death		4c. Cour	nty of Death		
	Funeral Director		579-64-2804	7. Age (In yrs. Is 7. Age (In yrs. Is	ast birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birth (Month, Day, 06 10	<sup>Year)</sup> 49	9. Birth Cou Virg	place (State intry) inia	or Foreigr
	land land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation			· · · · · · · · · · · · · · · · · · ·			10d. Inside (	City Limits
	Mary 1 sh	tor	MD Prince Ge	orges Ca	apito1	Heights						¥∰ Ye	s 2 No
	or 288	Director	10e. Street and Number			10f. Zip Code			1	0g. Citizen o	of What Cou	intry?	
	23a c		510 62nd. Avenue			2074	3			Ţ	JSA		
036	d within 72 hours after death with the Maryland Jene. Ir then "natural", or Items 23a or 28a-1 show Itte Macinal Examinat must be rediffed at	by Funeral	11. Marital Status  1 ☼ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ဩNo If Yes, Give Year or Dates:		Vas Decedent of f Yes, specify Cul I ☐ Yes 2 ☑ No	ban, Mexican	gin? (Spe 1, Puerto	ecify Yes or No- Rican, etc.)	8	lace - Ameri lack, White cify: Bla	, etc.	
Maryland 21215-0036	within 72 ho ene. then "natur he wedied	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give life. L	dent's Usual Occu kind of work done DO NOT use retire er/Wareh	e during mosi ed)		ng	16b. Kind of Depart Servic	ment	of Hur	nan
land 2	be file tal Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last)  Henry Badgett				18. Mothe	er's Name	(First, Middle, M				
ary	2 should and Men Is marke surmatic	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin	g Address (Stree	t and Numbe	er or Rura	i Route Number	City or Tow	vn, State, Zi	p Code)	
	and ealth n 27 ner tr		Rose Jones/Aunt 20a. Method of Disposition	1-21-21	3003_	Van Ness	s St.						
Baltimore,	permit. Pages 1 Department of H Importent: If iter any Injury or oth		20a. Method of Disposition  1 2 Burial 2 Cremation 3 □ R  1 □ Donation 5 □ Other (Specify)	emoval from State	ace of Dispo metery, crem t Line	sition (Name of natory or other pla		1-19		20c. Location Brentw			
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service License	hall		Name and Addr 217 9th.							
	Pnysician /Medical		23a. Part   Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death re cause on each line.	. Do not ente	Properties of the mode of dy Arr	ing, such as	cardiac o	r respiratory arre	nst,	,	Approxima Interval Be Onset and	tween
,8760,	cate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Char	ence of):	An	1220S	:Clr	RUSIJ				
O. Box 6	e death certifi he attending I led for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq Yes \) 2 \( \subseteq No \) 9 \( \subseteq Unknown \)	3c. If yes, outcome of pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnand Other (specify)	су				Date of deliv	ery Day	Year
<u>α</u>	quires that the n signed by t uld be detach	by	Part II. Other significant conditions cor	itributing to death but not resu		nderlying cause g	iven in Part I.		23e. Did tob	acco use co		he cause of	
Vital Records,	The law requir ate has been si page 2 should	Completed							24a. Was ar autops perform	/	D. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings impletion of	available cause of
ita	iclan: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place	of Death	(Check only one			-	
of \	Physician: this certific ral director,	2	1 ☐ Yes 2 🔀 No		R/Outpatien	L 3L DOA			ne 5 Reside			fy)	
Divislon (		Certification;	27. Manner of Death  1 ⊠Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		uryat ork? ∐Yes 2∐!		28d. Describe ho	w injury occi	urred		
Divi	Hospitel or Attending 44 hours after death. Funeral Director: After tely filled in by the fune		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, stre	eet, factory, office		2	28f. Location (Str City or Town		nber or Rur	al Route Nur	nber,
	To the Hospitel or within 24 hours after To the Funeral Dircompletely filled in	ledical	(Check only 2 Medical Examinate)	sician: To the best of my knowner: On the basis of examinati and manner stated.	riedge, death on and/or inv	vestigation, in my	opinion, deal	d place, a th occurre	ed at the time, da	te and place	e, and due t	o the cause(	s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			1	se number	1.4	25	d. Date sign		Day, Year)	
•	(		INC In	WD			568	11		11-1	4-05		
<u> </u>	(5)			mpleted cause of death (Item	23a) (Type,	/06	BUN	15	meet	9	LKI	ON, NO	10
	Sta Regist		31. Date filed (Month, Day, Year)  NOV 2 2 2005	2. Registrar's Signate	uré dina	E)							

ORIGINAL

39315

<b>Physician</b>
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel, or iteme 23e or 28e-f show eny injury or other treumette event, I're Madical Examinat must be natified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	Registrer					tificate o	r Deam			Reg. No	0.	
	1. Decedent's Name (First, Midd	le, Last)							2. Date of	Death		3. Time of Dea
in al	Robert Samue	1 Be11	Jr.						Month Nov.	19,		3:30 p
aı er	4a. Facility Name (If not institutio					4b. City, Town	, or Location	of Death			c. County of Dea	
	Prince George'	s Medi	cal Cen	ter		Cheve	er1v				Prince	George's
	5. Social Security Number	6. Sex 1⊠ M 2		(In yrs. last l		If Under 1 Year Months Day	ar If Under	24 Hrs. Min.	8. Date of (Month.	Birth Day, Year	9. Bi	rthplace (State or For
	218-16-2101	I KON IVI Z		81	Yrs.				Jan.		1924 Newp	ort News, V
	Usual Residence of Decedent 10a. State 10b. County	,		10c. City, To	own or Loc	ation						10d. Inside City Lir
o		nce Geo				r1boro						1 □ Yes 24□
Director	10e. Street and Number	ice dec	rige s	орр	er Ma	10f. Zip Code				10a C	itizen of What C	
ă	11003 Joyceto	n Driv	e				774				USA	ountry:
Funeral	11. Marital Status		as Decedent E	ver in U.S.	13. W	/as Decedent o		igin? (Spe	ocify Yes or	1	14. Race - Am	encan Indian
돌	1 ☐ Never Married 2K Mar	1 A -	med Forces? ∑Yes 2 □ No			Yes, specify Co	uban, Mexicar	n, Puerto	Rican, etc.)		Black, Whi	
þ	3 Widowed 4 Divorced	i If	Yes, Give ear or Dates: 1	2/45	1	☐Yes 2⊠N	No Specify:				Specify:	White
Completed		nt's Education		16		ent's Usual Occ				16b. l	Kind of Business	s/Industry
pje	(Specify only higher Elementary/Secondary (0-12)	<del></del>	ollege (1-4or 5+	+)	life. D	ind of work dor O NOT use reti	ired)	t of work	ng			
Con	12				Cere	emic Ti	le Set	ter			Constru	uction
Be	17. Father's Name (First, Middle,	*	C						•		n Surname)	
٩	Robert Samuel	ReTT,	Sr.				Fri	eda (	Gertru	ıde El	hoff	
	19a. Informant's Name/Relations	ship <i>(Type, Pi</i>	rint)	15	9b. Mailing	Address (Stre	et and Numbe	er or Rura	il Route Nui	mber, City	or Town, State,	Zip Code)
	Dorothy M. Be	<u> 11 - Wi</u>	ife	1	1003	Joycet	on Dri	VE. I	Jpper	Mar11	ocation - City o	20774
	20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation	3 □Remov	al from State	ceme	terv, crema	atory or other b	olacel '					
	'4 □Donation 5 □ Other (			George								Maryland
	21. Signature of Funeral Service	Ucensee *									ral Home	e, P.A.
	Hen K. UE	luffe 1			4/3	39 Dalt	imore A	Ave.	Hyat	tsví	lle, MD	20781
	23a. Par 1. Enter the disease, o s ick, or heart failure. Lis Imme, ate Cause (Final disea e or condition resulting in death)	r cometication t only one cau	H 3	e. Destru	w	r the mode of d	tying, such as	cardiac	or respirator	y arrest,	4	
i Examiner	Immediate Cause (Final disease or condition	a b c	H 3	const ueno	ce of); ce of);	Enc Enc E' 14e	tying, such as	factor of the state of the stat	or respirator	y arrest,	of in	Approximate Interval Betweer Onset and Death
	srick, or heart failure. Lis Immer late Cause (Final disea e or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events	a b c	ue to (or a a	const ueno	ce of); ce of);	e Ite	tying, such as	cardiac o	or respirator	y arrest,	of sie	Interval Between
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			1 - For State Registrar	State of Ma	aryland				ealth an D <i>eath</i>	d Me		giene Reg. No	000	393	46
	Discrete t		1. Decedent's Name (First, Middle, Las	1)						2	. Date of Dea	ath Da	y Year	3. Time	of Death
	Physicia /Medic		Margaret Delores	s Burke							Nov.	16,	2005	7:30	РМ
	Examin	er	4a. Facility Name (If not institution, give	·		1			Location of D	eath			. County of Dea		
			Gladys Spellman 1  5. Social Security Number 6. Se			ast birthday)		everl	.y If Under 24 I	Hrs. o	. Date of Birt		Prince (		
	Funeral Director				81	Yrs.	Months			lin.	(Month, Da	v. Year)		rthplace (State country) rginia	s or roreign
-			Usual Residence of Decedent								. 1 / 10 /		, , ,		
rylar	show Tel	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
M ec	8a-f oulfile	Director	Maryland Prince	George's	Hy	yattsv									s Z No
with	B or 2	吉	10e. Street and Number 6724 Stanton Road				10f. Zij	2078	4			-	tizen of What C JSA	ountry?	
eath	ns 23 Elusi	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. V	Vas Dece		spanic Origin	? (Specif	v Yes or No		14. Race - Am	erican Indian	
rs after o	Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other treumatic event, the Medical Examiner must be notified at once.	by Fun	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	11	Yes, spe	city Cubai	Specify:	uèrto Ric	ćan, etc.)		Black, Wh Specify: W	ite, etc.	
3 20	atura cal E		15. Decedent's Ed	ucation		16a. Deced						16b. K	(ind of Business	s/Industry	
<b>1</b> 22	Wedi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5	(4)	(Give . life. L	kind of wo	ork done d se retired)	uring most of	working				,	
W Mil	gien er th	E O	12			Hom	emak	er				Owr	n Home		
	d oth	Be	17. Father's Name (First, Middle, Last)						18. Mother's				,		
Z 2	Men	ပ္	Joshua Samuel Har								Louis				
, Mai	alth and 27 is n er treum		19a. Informant's Name/Relationship (7 Michael E. Burke				_		d, Hya			-	or Town, State, 20784	Zip Code)	
2 6	of He if iten or oth		20a. Method of Disposition  1 38urial 2 Cremation 3	Removal from State	Ce	ace of Dispos metery, cren	natory or o	ther place		Date			ocation - City o		
Pac	tent: jury c		* 4 □Donation 5 □ Other (Specify	)	Mar	<u> </u>							tenham.		
Der de	Depar Impor any in		21. Signature of Funeral Service Licen-	Sascho	lann	>							al Home Lle, MD		
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused one cause on each li	the death	. Do not ente	er the mod	de of dying	, such as car	diac or re	espiratory ar	rest,		Approxim Interval B	etween
	hysician		Immediate Cause (Final disease or condition resulting in death)	a ANTEN	Nosc	LENO	10	Can	DIOVA	اس،	LARI	215	Rail	Onset and	
	Medical xaminer		resulting in dealin)	Due to (or as	a consequ	ence of):								1	
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence of):									
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cate be executed	physician and s the burial-transit	dlcal	•	d											
o voi	ding p se as	/Med	IF FEMALE:	23c. If yes, outcome	of pregnar	acv.							2010-11		
d fee	atten for us	Physician/Me	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3	Ectopic p						23d. Date of de Month	Day	Year
; <sup>2</sup>	y the ached	hysl	1 Yes 2 No 9 Unknown	9□ Unknown											
uo, r	been signed by the attending p should be detached for use as	by	Part II. Other significant conditions of	ontributing to death b	ut not resu	lting in the ur	derlying	ause give	n in Part I.		23e. Did to		use contribute t	o the cause of	
	bluods	etec	Diabetes mu	1121						_	24a. Was			utopsy finding	
	feath.  for: After this certificate has the funeral director, page 2	Completed	- orangeres mo	11,705							autop perfor	sy med?	prior to death?	completion of	cause of
ָבֵּי ב <u>ַ</u>	tificat tor, pa	0	25. Was case referred to medical						26. Place of	Death (C		2 No	1 L Ye	s 2 No	
VSici	is cer direc	To B	examiner? 1 ☐ Yes 2 █ No	Hospital: 1   Inpatie	ent 2 🗆 E	ER/Outpatien	3 D	Othe	r /				6 ☐Other (Spe	ecify)	
5 á	fter th		27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury		28c. Injury Work	at ?	280	d. Describe h	ow inju	ry occurred		
	eath. for: A the fu	catle	2 Accident investigation 3 Suicide 6 Could not be				М		'es 2 □ No						
	after d Direct d in by	Certification:	4 Homicide determined	28e. Place of Inj building, et	ury - At hor c. <i>(Specify)</i>	me, larm, stre )	et, factor	y, office		281	Location (S City or Tow		nd Number or Fi e)	ural Route Nu	mber.
Hospits	within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as	edical C	29a. Certifier 1 Certifying Phyone 2 Medical Exam	ysician: To the best liner: On the basis o and manner sta	examinati	vledge, death ion and/or inv	occurred	at the tim	e, date and pl inion, death o	ace, and	due to the oat the tale	ause(s) date and	) and manner a d place, and du	s stated. e to the cause	(s)
To the	To the	Me	29b. Signature and title of certifier	No	, .	, ,	7 29	c. License	number			29d. Da	te signed (Mon	th. Day, Year)	
,-	3		1 Janell	nder!	re	me		00	1850	2	/	Vove	SMBER I	8,200	5
	) }		30. Name and address of person who o						100	00-					
,				203 Queens			yatts	SVILL	e, MD	207	ŖΙ				
	Sta Registr	_	NOV IIIad (Youth Day Year)	32. Renistr	ar s small										

		1 - For State Registrar	State of Maryla	ind / Depa		Health and		2005	39347
Physic /Med		Decedent's Name (First, Mid     CHARLIE ALBE:	•		initial of		2. Date of Death Month	Day Year 14, 2005	3. Time of Death 7:00 p M
Exam Funera	iner	4a. Facility Name (If not institut. 6701 Rhode I. 5. Social Security Number	sland Avenue  6. Sex 7. Age (In yr.	s. last birthday)	,		ath	4c. County of Dead	eorge 's hplace (State or Foreign
the Maryland 28s-1 show		260-16-7066  Usual Residence of Decedent  10a. State 10b. Coun  Maryland Print  10e. Street and Number	ty 10c. 0	Yrs.  City, Town or Lo				. Citizen of What Co	th Carolina  10d. Inside City Limits  1 XYes 2 No
If E, INICITY CLICIO-000  Is 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. If the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Example of the Louisity of the allowed on the configuration.	d by Funeral Director	6701 Rhode I:  11. Marital Status  1 Never Married 2 Mi 3 🖫 Widowed 4 Divorce	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 No W	JTT	2074	Hispanic Origin? ban, Mexican, Pue		. S . A . 14. Race - Ame Black, Whit	nican Indian,
filed within 72 h Hygiene. other then "natuent, the Medical	e Completed	15. Deceded (Specify only high Elementary/Secondary (0-12 1 2 17. Father's Name (First, Middle 17. Father) (First, Middle 17. Father		(Give	DO NOT use retir	e during most of w ed) nstrumen	vorking	Research	Industry
'E', M'ATY JAINO, 1 and 2 should be fill Health and Mental Hy tem 27 is marked oth	To Be	John Bat 19a. Informant's Name/Relatio Paul Batten	nship <i>(Type, Print)</i> - Son	670	l Rhode	Luci stand Number or H	nda Creec Rural Route Number, C venue, Col	h City or Town, State, 2 Lege Park,	MD 20740
permit. Pages 1 Department of H Important: If the any injury or oth	olleg.	20a. Method of Disposition  1 Maurial 2 Cremation  4 Donation 5 Other  21. Signature of Funeral Service	(Specify) Ga	ate of		metery 1		eral Home,	ing, Marylan P.A.
Physiciar /Medica Examine	1	shork, or heart failure. Li Immedi: e Cause (Final disease or condition resulting in death)	or complication, that caused the desist only one cause on each line.  a. Coronary A  Due to (or as a conse  Hypertensi	ath. Do not ent Artery I equence of):	ter the mode of dy				Approximate Interval Between Onset and Death 1 Year
box oo/ou, death certificate be executed e attending physician and d for use as the burial-transit	Icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last	b. Due to (or as a conse	equence of):					
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3	Ectopic pregnan Other (specify)	cy		23d. Date of del Month	ivery Day Year
law requires that the as been signed by the 2 should be detached.	b	Part II. Other significant condi	itions contributing to death but not re	esulting in the u	nderlying cause g	iven in Part I.	1 ☐ Yes		obably 4 Dunknown
VICAL NEC vician: The law certificate has t rector, page 2 s	e Completed	25. Was case referred to media	cal			26 Place of D	24a. Was an autopsy performs 1 Tyes 2 2 eath (Check only one)	d? prior to death?	topsy findings available completion of cause of
ng Phys fter this	Certification: To B	3 ☐ Suicide 6 ☐ Coul	28a. Date of Injury (Month, Day Year) Id not be		f 28c. Inju	ther: 4 Nursing ury at ork? Yes 2 No	Home 5 X Residence 28d. Describe how	injury occurred	
To the Hospital or Attendity within 24 hours after death. To the Funeral Director: A completely filled in by the to		4 ☐ Homicide dete	mined 288. Place of Injury - At building, etc. (Specific properties)	cify) nowledge, deati	h occurred at the	time, date and place	City or Town, s	se(s) and manner as	stated.
To the H Within 24 To the Fi	Medical	29b. Signature and title of certification	al Examiner: On the basis of examinand manner stated.	nation and/or in		ise number	29d	Date signed (Month	n, Day, Year)
IV9 S Regis	itate	30. Name and address of person Mark Parkhurst 31. Date filed (Month, Day, Yea NOV 2 2 2005	on who completed cause of death (It.  MD 5711 Sarvi  32. Registrar's Sig	s Avenu	•	, Riverda	ıle, Maryla	and 20737	
110913			1	-					

			For State Registrar	State of N	Marylan		artment of latificate of		d Mental Hyg	giene Reg. No.	005	39348
P	hysici	an	1. Decedent's Name (First, Middle Merton Ward Br						2. Date of Dea Month Novemb		5 2018	3. Time of Death 9:30 A M
	/Medic xamin		4a. Facility Name (If not institution 301 South Mair	, give street and number	ər)		4b. City, Town, o			4c. C	County of Death	
	neral ector		5. Social Security Number 216-07-4064	6. Sex 7 1 ☑ M 2 ☐ F	Age (In yrs. I	last birthday) Yrs.	If Under 1 Year Months Days		lin. B. Date of Birth (Month, Day Decembe	h v. Year) r4,19	9. Birth Cou Mary	place (State or Foreign ntry) Yland
he Maryland	offiled at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland Dorche	ster	10c. City	y, Town or Lo	ck					10d. Inside City Limits 1 X Yes 2 □ No
h with t	at De D	ai Dir	10e. Street and Number 301 South Main	Street			10f. Zip Code	1643		10g. Citize	en of What Cou USA	ntry?
yiang 21215-19-0030 ould be filed within 72 hours after death with the Maryland Mental Hygiene.	d other than "natural", or teme 23s of 28sh enow event, the Medical Examinat must be notified at	by Funeral Directo	11. Marital Status 1 ☐ Never Married 2 🛣 Marr 3 ☐ Widowed 4 ☐ Divorced	12. Was Decede Armed Force ied 1 X Yes 2 [ If Yes, Give Year or Date:	s? ]No 19	742	Was Decedent of I I Yes, specify Cub		(Specify Yes or No- lerto Rican, etc.)		4. Race - Ameri Black, White, Specify: Wh:	
within 72 ho	than "natur ne Madical	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12) 10	s Education of grade completed)	or 5+)	16a. Deced (Give life. I	tent's Usual Occu kind of work done DO NOT use retire	oation during most of d)	working		d of Business/In	,
Viana 21	rked other tic event.	To Be Co	17. Father's Name (First, Middle, Merton Ward Bra			OWITE	· •		Name (First, Middle, Crumpler			
Viar 12 sh h and	Treum Treum	•	19a. Informant's Name/Relations Don W. Bradley						Rural Route Numbe		Town, State, Zip	Code)
Department of Health	nt: If item ry or othe		20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 4 □ Donation → □ Other (S		re l		sition (Name of natory or other pla hington C	1	Date 19/2005		ation - City or To	
<b>Dalti</b> permit. Departm	any injury once.		21. Sign tur of Funeral Service		ler	Ze		ess of Facility Leral Ho	me, P. O.			
Phys /Me	ician dical		294. Pagh. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. ARTEK	ine.	Do not ent	er the mode of dyi	ng, such as card				Approximate Interval Between Onset and Death
	niner transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Unionlying Cause (Disease or injury that initiated events	b. — Due to (or a	as a consequ	uence of):						
cate be executed	physician and s the burial-transit	dicai	resulting in death) Last	Due to (or a	as a consequ	uence of):						
Geath certif	ed by the attending p detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal at time of de	death 3	Ectopic pregnanc	у	745	23	d. Date of delive Month	ery Day Year
Ţ.	29 g	þ	Part II. Other significant condition	ons contributing to death	but not resu	ulting in the u	nderlying cause gr	ven in Part I.		obacco uso	1/	he cause of death? pably 4 Unknown
The law	certificate has been si rector, page 2 should l	Completed	CORONAR	Y ARTE	RY	DisE	EASE		24a. Was a autop perfor 1 🗆 Yes	sy	24b. Were auto prior to co death? 1 \( \subseteq Yes	psy findings available mpletion of cause of
		o Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:	atient 2	ER/Outpatien	t 3 DOA Ott		Death <i>(Check only or</i> g Home 5 <b>X</b> Resid		Other (Specif	iv)
ION OI nding Phy	<u> </u>	ation; T	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	28a. Date of Ir (Month, I		28b. Time of Injury	28c. Inju Wo		28d. Describe h			,,
DIVISION To the Hospital or Attending within 24 hours after death.	filled in by the	Certification;	3 Suicide 6 Could 4 Homicide determ	ined 280. Place of	Injury - At ho etc. (Specify	ome, farm, str	eet, factory, office		28f. Location (S City or Tow		Number or Rura	al Route Number,
he Hospi n 24 hour	to the Funer completely fill	edical	29a. Certifier 1 Certifyir (Check only one) 1 Medical	g Physician: To the be Examiner: On the basis and manner	of examinat	wledge, death tion and/or in	occurred at the ti restigation, in my	me, date and pla opinion, death of	ace, and due to the occurred at the time, o	ause(s) a date and p	nd manner as s place, and due to	tated. the cause(s)
Tot	01	Σ	29b. Signature and title of certified Makbube	Alehter			29c. Licens	se number 10335	59	29d. Date	signed (Month,	2005
			30 Name and addless of person	who completed cause of	death (Item	23a) (Type	BOO A	uror	aSt.	Ca	mbride	je Md ziuce
I . I	Sta Registr		31. Date filed (Month, Day, Year)	1 8 2005 Regi	stra s Signa	ture &	Sprott	,				J

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygießen Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Rebecca Corum Month Year **Physician** Belva 4:00 P November 29 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Lorien Taneytown Taneytown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | Feb. | 6, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 220-05-2693 85 1920 New York Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "natural", or iteme 23a or 28e-1 show other traumatic event. It is Medical Examinar must be notified at 1 X Yes 2 ☐ No Maryland Carroll County Taneytown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with York Street 21787 61-A United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: white If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental f Health and Menta item 27 is marked Samuel Calvin Ramsburg Eve Margaret Schley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3846 Littlestown Pike Westminster, Md. 21158 Rebecca Dutterer / daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 0 = Trinity Lutheran Cemetery Dec. 2, 2005 6 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: if any injury or 4 ☐ Donation 5 ☐ Other (Specify) Taneytown, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Skiles Funeral Home 136 East Baltimore Street Taneytown, Md. 21787 urur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) uscular **Physician** /Medical Due to (or as a consequence of) Examiner elenoro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to k as a consequence of). Examine The law requires that the death certificate be executed burial-transit Sc Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the be detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has rmed? 2⊡No 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 Tes 2 No within 24 hours after death.

To the Funeral Director: A 2 Accident investigation the 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only onel the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olm 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death VOV 4a. Facility Name (If no 4b. City, Town, or Location of Death 4c. County of Death a emic 0 If Under 24 Hrs. Hours Min. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months 1 M 2 F Days 8/29/1950 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Marvland Wicomico Salisbury 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 218 Hazel Ave. 21801 USA 11. Marital Status Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Roofer Roofing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph C. Cumberland Jessie Juanita Webster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise M. Cumberland/sister 10818 Hobbs Station Rd., Louisville, KY 40223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 11/17/05 Salisbury, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Home Professional Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 105 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 ☐ Yas 2 ☐ No 3 ☐ Probably 4 ☑ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1110 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide

**Physician** /Medical Examiner use as the burial-transit and After this certificate has been signed by the ettending physician funeral director, page 2 should be detached for use as the buna Box 68760. P.O. Records, Vital ð Director: After Division To the Hospital or Attendin within 24 hours efter death.

To the Funeral Director: Af completely filled in by the fu

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

**Funeral** 

Director

item 27 is marked other then "natural; or items 23a or 28e-f sho other traumatic evant, the Medical Examiner must be notified at

at Hygiene.

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permit. Peges Depertment of H Important: if ite

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Maryland 21215-0020

altimore,

Hems

State Registrar and address of person who completed cause

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

29c. License number

2 Madical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year,

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

29b. Signature and title of certifier

NOV 1 8 2005

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First Middle 1 ast) 2. Date of Death **Physician** Month OTTO ARTHUR CHRISTOFFERSON NOV 23 /Medical 2005 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1**X**M 2□F Director 060-44-1243 JULY 3, 1951 MISSOURI Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28e-f ehow 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 □ No VIRGINIA **ALEXANDRIA** ALEXANDRIA the 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? with or iteme 23s 5555 HOLMES RUN PARKWAY Completed by Funeral death 22304 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filled within 72 hours after onent of Health and Mental Hygiene. Sont: if item 27 is marked other then "natural; or item Amed Forces?
1 Sayes 2 □ No 6/30/74
If Yes, Give
Year or Dates: 11/23/05 Black. White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: CAUCASTAN 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MASTER CHIEF PETTY OFFICER US COAST GUARD 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) OTTO ANTHONY CHRISTOFFERSON ျှ AUDREY COLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: if item 27 is any injury or other trau once. DEBORAH A. CHRISTOFFERSON-WIFE 5555 HOLMES RUN PARKWAY, ALEXANDRIA, VA. 22304 20a. Method of Disposition Ob. Place of Disposition (Name of ARITHGTON tory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) NATIONAL CEMETERY 12/27/05 ARLINGTON, VA 22. Name and Address of Facility ARLINGTON FUNERAL HOME 21. Signature of Funeral Service Licensee 3901 N. FAIRFAX DR., ARLINGTON, VA. 22203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart there. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC COLON CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): ettending physician a for use as the burial-Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death Month Day Year 5 Other (specify) ☐Yes 2☐No been signed by the c should be detached P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 24a. Was an has autopsy performed? 1 Tes 2 XNo 1 Yes 2 \ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No funeral dir this Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No the f 2 Accident 3 ☐ Suicide 6 □ Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D39709 11/25/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER LOUIS R. CANTILENA BETHESDA MD 20889-5600 31. Date filed (Month, Day istrar's Signature State Registrar

			For State Registrar	State of Mai	ryland / Depa <i>Cel</i>	artment rtificate				Pref )	5 3	39353
			Decedent's Name (First, Middle, Last)						2. Date of Death Month	Day	Year	3. Time of Death
	Physicia /Medic			Le P. Davi	is				11	19 2	2005	7:25 P. <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give st MALCOLM GROW MEDIC		ı			ation of Death		4c. County		oce I c
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1	Year If L	Jnder 24 Hrs. ours Min.	8. Date of Birth	PRINCE		ace (State or Foreign
	Director		244-26-9184	M 2 A F 80	Yrs.	Months	Days Ho	Juis Will.	July 7,1	925	North	"Carolina
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation					10	Dd. Inside City Limits
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	ath wi	rai	2306 Olsen St.				20748				USA	and the state of
36	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or itams 23e or 28e-f show event, the Medical Exam her must be notified at	by Funerai	11. Marital Status  1 Never Married Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Every Armed Forces?</li> <li>1 Yes 2 Notes</li> <li>1 Yes, Give Year or Dates:</li> </ol>		Was Decede If Yes, specif		exican, Puerto	acify Yes or No- Rican, etc.)	Blac	e - America ck, White, e c: Whi	etc.
2-0	72 hou	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual kind of work	Occupation	g most of worki	ng 16	3b. Kind of Bu	usiness/Ind	lustry
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d 2	filed v Hygie othar t	e Co	12th 17. Father's Name (First, Middle, Last)		ncciv.	I CI CO			(First, Middle, Ma			K5/ RCC :
lan		To B	Jonah Parrish				L	ettie	Brannon			
	CA 02		19a. Informant's Name/Relationship (Type James P. Davis/Hust						Hills, M	-		Code)
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or othar tr once.		20a. Method of Disposition  XXBurial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place of Dispo cemetery, crea Maryland	matory or oth Vetera:	ne <i>r place)</i> ns Cei	n.Nov.	23,2005		nham,	MD.
Balti	perrit. Departm Importa any Inju		21. Signature Funeral Service License	6/1					. Kalas Oxon Hil			
1	Pmysician		23a. Parti. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition	eations that caused to be paids on each line STROKE	the death. Do not en	ter the mode	of dying, su	ich as cardiac c	or respiratory arres	t,		Approximate Interval Between Onset and Death 1 HOUR
	/Medical		resulting in death)	Due to (or as a	consequence of):							
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oʻ	an and rial-tra	Еха	that initiated events c. resulting in death) Last	Due to (or as a	consequence of):							
8760,	ate be hysicii the bu	dicai	L d									
Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 (M) No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death 3	⊒Ectopic pre ⊒ Other (spe					te of delive	ry Day Year
P.0	that the died by the detached		Part II. Other significant conditions con	tributing to death bu	t not resulting in the u	inderlying ca	use given in	Part I.	23e. Did toba	icco use cont	ribute to th	ne cause of death?
ds,	uires tha signed I	d by							1 🗆 Yes	2 <b>X</b> No	3 🗆 Prob	ably 4 Unknown
Records,	The law requir te has been si age 2 should	Completed							24a. Was an autopsy perform	ed?	prior to cor death?	psy findings available inpletion of cause of
Vital		BeC	25. Was case referred to medical examiner?				111		(Check only one	)		
of V	Physic this ce al dire	2	1 ☐ Yes 2X No	ospital: 1 Inpatien					me 5 🗀 Residen 28d. Describe hov			")
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Division	or Attending Physician: after death. Diractor: Atter this certific in by the funeral director,	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At home, farm, st . (Specify)	reet, factory,	office		28f. Location (Stre City or Town,		oer or Rura	l Route Number,
_	To the Hospital or Attenc within 24 hours after death To the Funeral Diractor: completely filled in by the	Medicai C	29a. Certifier Check only one) Certifying Phys	ician: To the best of er: On the basis of and manner stat	f my knowledge, dea examination and/or in led.	th occurred a nvestigation,	t the time, o	late and place, on, death occurr	and due to the cau ed at the time, dat	ise(s) and ma e and place,	anner as st and due to	ated. the cause(s)
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R	(5)		30. Name and ddress of person who co	J, USAF	1050 W. PI	ERIMET	ER RD	ANDREW	S AFB, M	2076	2	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 2 2 2005	3 Registra	r's Signature	The same						

State of Maryland / Department of Health and Mental Hygiene 15 1 - State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Littman Danziger ĨO, November 2005 10:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Carriage Hill Nursing Home Bethesda | Settle Sua | If Under 14 Hrs. | 8. Date of Birth (Month, Day, Year) | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North | North 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Months 1□M 2 1 F Poland Yrs 94 Director 579-20-5329 Usual Residence of Decedent filad within 72 hours after death with tha Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits rthan "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Pompano Beach FT. Broward 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Blvd. #1807 33062 United States 1360 South Ocean Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 X Yes 2 □ No If Yes, Give 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WW-II 1 ☐ Yes 2 🔀 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Retailer Own Business is marked other other treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Kestenberg Yisrael Pesach Danziger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree 6624 Quaker Ridge Road No. Bethesda MD 20852 Arnold J. Danziger, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State v injury or 1X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Adas Israel Cemetery 11-13-2005 Washington, DC 21. Signature of Funeral Service Liceosee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Inc. 11800 New Hampshire Ave Silver Spring MD 20904 23a. Part1. Enter the disease or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hypertensive Heart Disease /Medical Due to (or as a consequence of). **Examiner** Atrial Fibrillation Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner The law requires that the death certificate be executed Cerebrovascular Accident attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Dementia IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 þe 1 Tyes 2 □ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy certificata 1 ☐ Yes 2 XNo To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 No 2 ER/Outpatient 3□ DOA After this funeral 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury 1 ☐ Yes 2 No 2 Accident investigation Director; 3 🔲 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) within 24 hours a 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Mosun U D0047330 November 11, 2005 duonus

DHMH 17 Rev 1/2001

State

Registrar

20852

Thomas Joseph, M.D. 50 West Edmonston Drive, Rockville, MD

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

18

/Medical	Mamie	2	t)	Frazier			2. Date of Death Month November	Day Ye	0:/D K
Examiner		(If not institution, give			4b. City, Town, or Baltimo	Location of Death		4c. County of E	*
Funeral Director	5. Social Security <b>254–38–2</b>	Number 6. Se 1	7. Age	88 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 2/22/191	9. <b>7 Th</b>	Birthplace (State or Foreig Country)  Ompson, GA
show adat	Usual Residence 10a. State MD	10b. County Prince G	eorge¹s	10c. City, Town or L					10d. Inside City Limit
ms 23a or 28a-f show count be notified at neral Director	10e. Street and N 8301 Og		street		10f. Zip Code	20784	10	g. Citizen of What	
xamma by Fur		rried 2 Marned	12. Was Decedent I Amed Forces? 1  Yes 2  If Yes, Give Year or Dates:	Ever in U.S. 13	Was Decedent of H If Yes, specify Cuba  1 ☐ Yes 2 No	Ispanic Origin? (Spe an, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc. Black
d other than "natural", svent, tra Modele Ex.  Be Completed by	(Spe Elementary/Sec	15. Decedent's Ed ecify only highest grad condary (0-12)	ucation de completed) College (1-4or 5	7)	edent's Usual Occup e kind of work done o DO NOT use retired memaker	ation during most of workir 1)	ng 1	6b. Kind ol Busine  Domes	•
svering Be		(First, Middle, Last)				18. Mother's Name		aiden Sumame)	
<b>~</b> ₽	19a. Informant's Gwendo	Name/Relationship (7 Lyn E. Ste	ype, Print) wart( daug	thter) 19b. Mai	ing Address (Street of Ol Ogleth	and Number or Rura	Route Number, New Carr	City or Town, State 11ton,	te, Zip Code) MD 20784
Important: If Item 27 I any Injury or other tra once.	4 Donation	Cremation 3 5 Other (Specify	2	Fort Lin	omatory or other place coln Ceme	tery 11/2	L/2005 B		, MD
any in	21. Signatur	Service Lifen	S88		2. Name and Addre	ensburg For	rt Linco Road Br	ln Funer entwood,	al Home MD 20722
n and ial-transit and ial-tran	shock, or he shock	eart failure. List only of (Final ion )  conditions, immediate lerrying or injury its	b. — Due to (or as	μe.	rs Dem				Approximate Interval Between Onset and Death
		(	d						
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Inter this certificate has been signed by the attending physicie funeral director, page 2 should be detached for use as the but lon; To Be Completed by Physiclan/Medical	23b. Was deceded in the past 1    Yes 2   9	erred to medical  No ath  5 Pending investigation 6 Could not be determined	Hospitat: 1 Inpatie  28a. Date of Inju (Month, Da)  28e. Place of Inju building, etc.	2 Fetal death 3 time of death 5 time of death 6 time of death	Other (specify)  underlying cause give  ent 3 DOA Other  of 28c. Injur  Wor  M 1 Underlying cause give	en in Part I.  26. Place of Death er: 4 \( \text{Nursing Hor} \) yat k? Yes 2 \( \text{No} \)	1   Yes  24a. Was an autopsy perform 1   Yes 2'  (Check only one me 5   Resider 28d. Describe how 28f. Location (Strictly or Town,	Month  acco use contribut  No 3  24b. Wern prior deat 1 1  nce 6 X Other (3 vinjury occurred	Day Year  te to the cause of death?  Probably 4 Unknown  e autopsy findings available to completion of cause of h?  Yes 2 No  Special C
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiepe 1 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav Year **Physician** Bertha Viola Ford 10:30 P.M. 17, 2005 November /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Prince George's Cheverly Prince George's Hospital Center 7. Age (In yrs. last birthday) 85 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M **X**(X)F Yrs Director 578-16-8182 2/7/20 Washington, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, It e Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 ☐ No Director D.C. Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20002 U.S.A. 1714 Bay St., S.E. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married African-1 ☐ Yes 2X No Specify: altimore, Maryland 21215-0020 Specify: ģ American XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Industry 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Ware ٩ Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4519 Woodgate Way, Bowie, Maryland 20720 Sandra L. Lyles/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 11/25/05 Landover, Md. Harmony Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
H.S.Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Washington, D.C. 20019 21. Signature of Funeral Service Licensee aug 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** & RUSTURED SURFARENAL ABDOMINAL AORTITIS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ATHERO SCLEROSIS attending physician end for use as the burial-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ANEURYSM ABDOMINAL Division of Vital Records, P.O. Box 68760, ADRTIC Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? has been signed by the age 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s certificate has director, page 2 1 Yes 2 100 1 Tyes 2 No or Attending Physician: : After this certific e funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4□ Nursing Home 5□ Residence 6□Other (Specify) 1 ☐ Yes 2 1 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No nerei Director: A / filled in by the fo 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours e Funerei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) Medical completely and manner stated. To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed causs of death (Item 23a) (Type, Print) NWANERI KEMPTON NGIOZIKA 7214 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar DHMH 16 Rev 6/95

NOV 2 2 2005

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) **Physician** NOVEMBER 20 3:45 PM M MAVIS D. FOWLER 2005 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** MONTGOMERY HOSPICE CASEY HOUSE ROCKVILLE MONTGOMERY If Under 1 Year If Under 24 Hrs. Months Days Hours Min. July 9 1919 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 K F 86 Yrs INDIANA Director 084-28-6518 Usual Residence of Decedent with the Maryland 10a, State 10b. Count 10c. City. Town or Location 10d. Inside City Limits "natural", or Itema 23s or 28s-f ehow circal Examiner must be notified at XXYes 2 No KENT CHESTERTOWN Directo MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 127 HERON PT. 21620 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after all Hygiene.
other than "natural", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No WHITE δ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ 12 HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant; if Item 27 is marked ot GEORGE QUINCY DUNLOP BERTHA WARNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GEORGIA M. RATLIFF/DAUGHTER 20337 WATKINS MEADOW DR., GERMANTOWN, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 permit. Page Department of Important: If any Injury or once. CHESAPEAKE CREMATION CTR. 11/23/2005 STEVENSVILLE, MD 21. Signature of Funeral Service Licensee PACE Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MOHN R. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC PANCREATIC ADEMOCARCINOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): be executed the burial-transit that initiated events resulting in death) Last igned by the attending physician and be detached for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 20 No 3 ☐ Probably 4 ☐Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 X No 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: after death. Director: After Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 To the Hospital o within 24 hours aft To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of sentifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES HARRISON M.D. 6001 MUNCASTER MILL RD., ROCKVILLE, MD 20855 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			State Registrar Americal ITem #23a		partment of Health a	Reg	
П	Physicia	an	1. Decedent's Name (1 1/3), Induite, East,		her	2. Date of Death Month November	Day 23, 2005 10:55pm <sup>M</sup>
	/Medic		Harriet Mar  4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of		4c. County of Death
	Examin	er	Buckingham's Choice	,	Adamstown		Frederick
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 X	F 99 Yrs.	Months Days Hours	Min. 8. Date of Birth Oct. 19,	9. Birthplace (State or Foreign Naryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Maryl fied a	tor	Maryland Frederick	Adamstow	n		1 ☐ Yes 2 X No
	h with the 23e or 28a st be noti	ai Director	10e. Street and Number 3200 Baker Circle		10f. Zip Code 21710	10g	D. Citizen of What Country?
36	ould be filed within 72 hours after death with the Maryland Mental Hygiene. Mental Hygiene. Marked other than "natural", or itema 23e or 28e-f show attice event, the Medical Examiner must be notified at	by Funerai	1 Never Married 2 Married 1 Yes	Decedent Ever in U.S. 13 d Forces? es 22 No , Give or Dates:	. Was Decedent of Hispanic Ori If Yes, specify Cuban, Mexican 1  Yes  No Specify:		14. Race - American Indian, Black, White, etc. Specify:White
Ş	2 hou	ted t	15. Decedent's Education	16a Dec	edent's Usual Occupation	16	b. Kind of Business/Industry
215	ithin 7 n° nar	Completed	(Specify only highest grade completed in the complete in the c	10 (1-40(5+)	re kind of work done during mos DO NOT use retired) Homemaker	t or working	Own Home
2	filed w Hygiel ther ti	CO	17. Father's Name (First, Middle, Last)	1		er's Name (First, Middle, Ma	
<u>a</u>	2 should be filed withir and Mental Hygiene. Is marked other than aumstic event, the Mi	To Be	· · · · · · · · · · · · · · · · · · ·	emp	Se	ophia Detric	k
lary	2 should and Men la marke raumatic		19a. Informant's Name/Relationship (Type, Print) Mrs. Elizabeth K. Roze		iling Address (Street and Number 3 Oakenshaw Pla		-
e,	1 and Health tem 27		20a. Method of Disposition	20b. Place of Dis	position (Name of		c. Location - City or Town, State
altimore, Maryland 21215-0036	Pages nent of int: If it iny or o		XXBurial 2 Cremation 3 Removal fit 4 Donation 5 Other (Specify)	om State   '	vet Cemetery Dec.	1, 2005 F	rederick, MD
Balti	permit Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic of once.		21. Sign ture of Funeral Service Licensee	M00706 1	22. Name and Address of Facili Keeney & Bast .06 East Church	ord P.A. Fund St. Frederic	eral Home ck, Maryland 21701
			23a. Pak 1. Enter the disease, or complications to shock, or heart ailure. List only one cause	nat caused the death. Do not e			Approximate Interval Between
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		Aspiration Pne	umonia	Onset and Death
	Examiner		Duc	e to (or as a fonsequence of):			
	D H	iner	cause. Enter Underlying	o to (or as a consequence of):			
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	e to (or as a consequence of):			
8760,	ate be executed hysician and the burial-transit	dicai E	d				
9	ndifica ng ph	Medi	IF FEMALE:				
P.O. Box	The law requires that the death certificate has been signed by the attending plage? Should be detached for use as to	Physician/Me	23b. Was decedent pregnant in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
	res that I igned by be deta	by Ph	Part II. Other significant conditions contributing	to death but not resulting in the	underlying cause given in Part I	. 23e. Did toba	cco use contribute to the cause of death?
rds	w requires been sig should b					1 🗆 Yes	2 No 3 Probably 4 □Unknown
Vital Records,		Completed				24a. Was an autopsy performe 1 ☐ Yes 2)	24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?  1. Type 2. Male Hospital:		Other	of Death (Check only one)	
	Attending Physician: r death. ector: After this certification the funeral director.	. To	27. Manner of Death 28a, D	1 ☐ Inpatient 2 ☐ ER/Outpati		rsing Home 5  Residence 28d. Describe how	
lon	nding I tth. :: After e funer	ation	1 Natural 5 Pending ( 2 Accident investigation	Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☐		,
Division of	al or Attendates after death	Certification:	3 🗀 Suicide 6 🗀 Could not be determined 28e. F	Place of Injury - At home, farm, suilding, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
		ai		o the best of my knowledge, de	ath occurred at the time, date an		se(s) and manner as stated. a and place, and due to the cause(s)
	he Hospital n 24 hours he Funeral I	edic			investigation, in my opinion, dea		
)	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Medical		he basis of examination and/or	29c. License number D58726		Date signed (Month, Day, Year)  Vember 25, 2005
)	To the Hospit within 24 hours To the Funers completely fille	Medic	29b. Signature and title of certifier  30. Name and address of person who completed	he basis of examination and/or manner stated.  - MYO cause of death (Item 23a) (Typ	29c. License number D58726 e, Print)	No	vember 25, 2005
	To the Hospit within 24 hour within 24 hour To the Funers completely fill St	Σ	29b. Signature and title of certifier  30. Name and address of person who completed  Yvette L. Warren, M.D.	he basis of examination and/or manner stated.  - MY  cause of death (Item 23a) (Typ  1., 1564 Opossu  2. Registrar's Signature	29c. License number D58726 e, Print)	No	vember 25, 2005

				For State Registrar	State o	f Mary	land / De <i>C</i>	partmer e <i>rtifica</i>					giene Reg. No.	005	393	359
	¥ ,			1. Decedent's Name (First, Middle,		0.11	1					2. Date of De Month	ath Day	Year	3. Time	ol Death
_	1	Physicia /Medic			Ella Mae	Godda	rd 					NOV	21	2005		1 A M
	1	Examin	er	4a. Facility Name (If not institution,	give street and nu	mber)		4b. City	, Town, or	Location	of Death			County of Dea		
	400	<u> </u>		CIVISTA MEDICA 5. Social Security Number	L CENTER 6. Sex	7. Age (In	yrs. last birthd		PLAT	'A If Under	24 Hrs.	8. Date of Bir	th	CHARLES		or Foreian
_		Funeral Director		578-36-9462	1□M 2፟MF	76	Yrs	Months	Days	Hours	Min.	(Month, Da Jan. 3,	y, Year)		rthplace (State ountry) ington.D	
D		AF.		Usuel Residence of Decedent										110222		
ARD		arylar show	<u>_</u>	10a. State 10b. County			c. City, Town o								10d. Inside	S 2 D No
		the M	ecto	Maryland Prince G	eorge's	T	'emple Hi		p Code				10a Citi	zen of What C		<i>X</i>
0		with a or	I Dir	3904 Triton Court				101. 2		20748			rog. Oit.	USA	outray:	
2		death with the Maryland me 23a or 28a-1 show rmust be rediffed at	Funeral Director	11. Marital Status	12. Was Dec	edeni Ever	in U.S.	3. Was Dece	edent of H	ispanic Or	igin? (Spe	ecify Yes or No	-	14. Race - Am		
6	9	or ite		1 Never Married 2 Marrie	Armed Fe ed 1 ☐ Yes If Yes, G				-	an, mexica Specify.		Rican, etc.)		Black, Wh		
9	93	72 hours after natural', or ite	d by	3 ☐ Widowed 4 ☐ Divorced	Year or E	Dates:		1 🗆 Yes			•				nite	
	21215-0036	"natu	Completed	15. Decedent's (Specify only highest	s Education grade completed)		(G	ecedent's Usi live kind of w le. DO NOT	ork done o	during mos	st of worki	ing	16b. Ki	nd of Busines:	s/Industry	
_	12	within ene. than "	omo	Elementary/Secondary (0-12)	College (	1-4or 5+)		nistrat		,	llerk		Priv	vate Indi	ıstry	
A		filed Hygir other	Be C	12th 17. Father's Name (First, Middle, L	ast)					18. Moth	er's Name	(First, Middle	, Maiden	Sumame)		
7	lan	Ald be Aental rked c	To B	Raleigh Baum						Naon	mi P	hipps				
1	Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Maralla Hygiens. Integration of Health and Maralla Hygiens. Integrated: If item 27 is marked other than "natural", or items 23a or 28a-1 show in from from the remaining from the ray injury or other traumatic event, Ite Marical Examinar must be notified at any injury or other traumatic event, Ite Marical Examinar must be notified at ange.		19a. Informant's Name/Relationship								al Route Numb		r Town, State,	Zip Code)	
M		and lealth m 27 her tr		Charles E. Goddard/	Husband	0.				t Tem		11s,MD. 2			- T C1-1-	
	Baltimore,	ges 1 It of H If ite or ot		20a. Method of Disposition  1 X Burial		State		crematory or	other plac					cation - City o		
	Ħ	it. Pa rtmer rtant njury		4 □Donation 5 □ Other (Sp. 21. Signature of Funeral-Service L.		11	aryland '			1		3,2005 Kalas Fi		cenham,M Lliome	) <b>.</b>	
	Ba	permit. Depart Import any in		An f. Hal								Hill, Md				
	1			23a. Part 1. Enter the disease, or o shock, or heart failure: List o		caused the								+	Approxim	nate
	1	Physician		Immediate Cause (Final disease or condition	Re	14)	tacci	(	-\alpha \ 1	du	co				Onset an	
	1	/Medical		resulting in death)	aDue to	(or as a co	nsequence on:	1 ,		' ( \	, <u> </u>	/\		1	ane	KNOW
		Examiner		Sequentially list conditions,	ь	COM	pent	Suke	Co	nye	save	. Hear	- 4	active	uni	9KO34
		sit 8d	lnei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a co	n <b>3e</b> quence of):	C. (		ر					Cont	Va (14.
		and and II-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a co	nsequence of):	4000	α/.						Sire	your
	8760,	cate be executed physicien and the burial-transit	dlcal E													
	687	g physi as the b	edic													
	Box 6	leath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou			3 □Ectopic	oregnancy	,			:	23d. Date of de	,	
	В	the att	sicis	in the past 12 months? 1 ☐ Yes 2 🏋 No		nant at time		5 Other (						Month	Day	Year
	<u>Р</u>	that the death ed by the atte detached for	Phy	9 Unknown  Part II. Other significant condition	se contributing to	death but no	at resulting in th	e underwing	Cause on	en in Part		23a Did i	obacco	ise contribute	to the cause o	of death?
	ds,	iw requires that s been signed b should be det	d by	Perinha	cas	VAS	cul a	- N	14/	426			Yes 2			nknown
	200	v requ been shoul	ete	N E	MARITI	A				130		24a. Was	an	24h Ware a	autonsy linding	ns available
	Re	he lav e has	Completed	1 1 200	1-151	> 1/1/	Locti	1000	R	leel	)	auto		death?	completion o	cause of
	tai	an: T tificati tor, pe	BeC	25. Was case referred to medical	UASI	010	, resi	Mal	17		e of Deat	1 ☐ Yes		1 1 46	s 2 No	
	Ţ	yeici iis cer direc	To B	examiner? 1 Tes 2 No	Hospital:	Inpatient	2 ER/Outpa	atient 3 🗆 🗅	Oth	or		me 5 Resi		6 □Other (Sp	ecify)	
	0 [	Attending Physician: The law requires that the death certific rideath.  ector: Atter this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as by the funeral director.	uo:	27. Manner of eath 1 Natūral 5 □ Pending	28a. ate (Moi	ol Injury oth, Day Ye	ar) 28b. Tim Inju	гу	28c. Injun Wor			28d. Describe	how injur	y occurred		
	sio	tendi leath. Ior: A the fu	cath	2 Accident investigation inve	ation	11.1	1	М		Yes 2		001 1		141 5		
	Division of Vital Records, P.O.	or At after d Direct in by	Certification:	4 Homicide determin	and 288. Plac	e of Injury - ding, etc. (S	At home, farm pecify)	, street, facto	ry, office			28f. Location ( City or To	Street an wn, State	a Number or F )	Hur <b>a</b> l Houte N	umber.
		spital ours a neral filled		29a. Certifier Certifying	Physician: To th	e best of m	y knowledge, d	leath occurre	d at the tir	me, date a	nd place,	and due to the	cause(s)	and manner a	as stated.	
		To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical		xaminer: On the l											9(s)
		To th withir To th comp	ž	29b. Signature and title of certifier	IVA	0 .	λ.	2	9c. Licens	e number			29d. Dat	e signed (Mor	oth, Day, Year	)
				Domiel	A QU	2m	on M	ン	D-00	26262	2		1 \	121	20,	
0	R	(3)		30. Name and address of person v											_	
	ا نسيا			SAMUEL J. KLET  31. Date liled (Month, Day, Year)			LIVINGS Signature -	TON R	). IC	CU D	EPT.	FT. WAS	SHINO	TON, M	D 2074	4
		Sta	пе	MOVOO			4	and a								

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	R	• <b>2</b> 005 39360
	Physici	ian	1. Decedent's Name (First, Middle, Lest)	2. Date of Deel Month	th Day Year 3. Time of Death
1	/Medio		4a Fecility Name (If not institution, give-street end number)  4b. City, Town, or,	Location of Death	4c. County of Death
	Examili	iei	PRINCE GEORGES HASPIGHT OF CHES	UPERY	Penter Geolges
	Funeral		5. Social Security Number  6. Sex  7. Age (In yrs. last birthdey) If Under 1 Year If Under 24 Hrs.  While the security Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Number of Nu	8. Date of Birth	(Year) 9. Birthplace (State or Foreign Country)
	Director		none   Yrs.   1	Nov 13	
	show star		10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
	e Mar	ctor	D.C. None Washington		Y Yes 2 □ No
	ih th	Director	10e. Street end Number 10f. Zip Code	1	0g. Citizen of What Country?
	ter deeth with the Maryle frems 23e or 28e-f shou ther revest be notified at	erai	3423 5th Street S.E. #23 20032		USA
21215-0020	# 6 E	by Funeral	If Yes, Give 1 ☐ Yes 2₹☐ No Specify: Year or Detes:	pecity Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
15-0	naturel',	etec	15. Decedent's Education 16e. Decedent's Usual Occupetion (Specify only highest grade completed) (Give kind of work done during most of work	king	16b. Kind of Business/Industry
121	within ene. then	Completed	Elementery/Secondery (0-12) College (1-4or 5+)		
	be filed withintal Hygiene.			ne (First, Middle, M	None Maiden Surname)
lan	should be filed and Mental Hygi s marked other umatic event, I	o Be			
Maryland	2 2 2 2		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	asha Glad rel Route Number,	OSTONE , City or Town, Stete, Zip Code)
	all stand	-	Natasha Gladstone (Mother) 3423 5th Street, SE #2		
Baltimore,	Peges ent of nt: If It			Date 2 1/17/05	Beltsville, MD
Ball	permit. I Departm Importar eny Inju		21. Signature of Fundral Service, Licensee  22. Name and Address of Facility	ndon/Hale	e Funeral Home
_	2020		1 Juli Cunu Jen 9013 Annapolis Road	d, Lanhar	n MD 20706
	Physician /Medical Examiner	1	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac short or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in deeth)  Extracc	or respiratory arre	est, Approximate Interval Between Onset and Death
	D ==	ner	Due to (or as a consequence of):		1
	es that the death certificate be executed igned by the attending physicien and be detached for use as the buriel-transit	Examiner	0.		
68760,	be exicien buriel	aiE	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events  Due to (or as a consequence of):		
687	ficate physics the	8	resulting in death) Last  Due to (or as e consequence of):		
Вох	anding use a	2	d		
	death	sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tob	Dacco use contribute to the cause of death?
P.O.	that the led by th detache	Phy		1 □ Ye	
ds,	res th signed d be d	þ			
Division of Vital Records,	The law requires ate has been sign page 2 should be	Completed by Physician/		24a. Was an perform	autopsy ed?  24b. Were autopsy findings available prior to completion of cause of deeth?
<u>e</u>	cate h	ဦ		1 ☐ Yes	s 2 No 1 Yes 2 No
ZE ZE	Physician: rthis certific rral director,	<b></b>	Hospital:	th (Check only one	
ō	Phys rthis eral di	2	27. Menner of Death 28e. Date of Injury 28b. Time of 28c. Injury et	ome 5 Resider 28d. Describe how	nce 6 Other (Specify)
<u>0</u>	Attending or deeth.  Ctor: After by the fune	atio	1 Netural 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		,,
<u>S</u>	r Atte ter der recto	120	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	eet and Number or Rurel Route Number, Stete)
۵	urs efter rel Dir illed in	Š			
	To the Hospital or Attending Physician: The law within 24 hours efter deeth.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edic	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, (Check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the cau red at the time, dat	use(s) and manner as stated. te and place, and due to the cause(s)
	Veit To To To	Σ	29b. Signature and title of confiner  2 6 8 1 9	29	d. Date signed (Month, Day, Year)
		1			"lielot"
1		et.	30. Name end eddress of pers in who completed cause of deeth (Item 23e) (Type, Print)  DR AGDUL CHAUDRY 3001 HOSPITAL DR C	HEVERLY	MD 20185
	Stat Registra		31. Date filed (Month, Day, Year)  NOV 2 2 2005	7	

MHW

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Year NOVEMBER 23, 2005 11:53 A<sup>M</sup> DANA GERONIMO /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY CO 20 W. DEER PARK ROAD # 203 GAITHERSBURG 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 XM 2 ☐ F Yrs. Director 213-94-7421 36 Jan25,1969 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at MD Montgomery Gaithersburg 1 Tores 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours atter death with I Depertment of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 3 ery injury or other treumatic event, the Medical Examinar must be ance. 4 Brighton Terr 20877 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ZCNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Thomas AA Moving Elementary/Secondary (0-12) College (1-4or 5+) & Storage llth Packer & Loader 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dale A. Geronimo Carole A. VanHorn ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale A. Geronimo- Father Brighton Terr Gaithersburg, MD 20877 20a. Method of Disposition 20b. Place of Disposition (Name of competer), crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro 4 ☐ Donation 5 ☐ Other (Specify) Finrl Svcs 11/30/05 Alexandria, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SnowdenFuneral Home PA 246 N. Washington St Rockville, MD20850 spege 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Betw tmmediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Methadone Intoxication /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atter e detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Tyes 2 No page 2 s has autopsy performed? ver 2 No To the Hospital or Attending Physicien: within 24 hours atter death.

To the Funerel Director: Atter this certifice completely filled in by the tuneral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) SCENE Hospitat: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA ۵ 1XXes 2 No 28c. tnjury at Work? 27. Manner of Death Certification; 28d. Describe how injury occurred 28a. Date of Injury F1100onth, Day Year) 286 Time of Influry unk 1 Natural 5 Pending investigation 1 Yes 2 No 11:30 A 2 Accident 11/23/05 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 20 W. Deer Park Rd Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide found at home #203, Gaithersburg, MD 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCME NOVEMBER 24, 2005 Sante 1 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Greenberg Min. 111 PENN STREET, BALTIMORE, MARYLAND, 21201 Tasha 31. Date filed (Month, Day, Year) 32. Fegistrar's Signature State 2005

DHMH 17 Rev 1/2001

Registrar

01

DEC

State of Maryland / Department of Health and Mental Hygiene 05 1 = For State Registrar Certificate of Death Rea. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 01:15 AM Anita Raye Grove 24 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. Jan. 7, 19 SACRED TSA3H HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Months 56 North Carolina 1 □ M 2525€ 235-72-1541 Director 1949 Usual Residence of Decedent the Manyland 10h County 10c. City. Town or Location 10d. Inside City Limits 10a State 28a-f ehow traumatic event, the Medical Examiner must be nutified at WV. Keyser 1 ☐ Yes ⊉ŒNo Mineral Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Items 23a or 26726 United States Rt. 3, Box 3212, Eagle Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2X Married Specify: white 1 ☐ Yes XXNo Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hair Styling Elementary/Secondary (0-12) College (1-4or 5+) Hairdresser 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominic Calemine Colleenn London 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Thomas Grove/ husband Rt. 3, Box 3212, Eagle Lane, Keyser, WV. 26726 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 11/26/ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Keyser, West Virginia St. Thomas Cemetery 4 Donation 5 Other (Specify) 2005 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses 111 Church St., Westernport, Maryland 21562 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death endometrial carcinoma Metastatic Immediate Cause (Final Physician disease or condition resulting in death) o mouth /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury Dualto for as a ponsequence of Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached it 0.0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Be Completed by 1 ☐ Yes 2 C No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25 No 1 Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 Empatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) After this funeral of 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Division 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the nause(s) and mention as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) NOVEMBER 25, 2005 D25406 Main 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland MD 31500 900 Seton Drive. mailli(1). AC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 28 2005 Registrar

			For State Registrar	State of Mary		partment of F certificate of i			2005	3931	63
	<b>.</b>		1. Decedent's Name (First, Middle, L	ast)				2. Date of Death Month	Day Ye	3. Time o	of Death
	Physicia /Medic		Gladys Evelyn (	Garland				November			100 M
	Examin		4a. Facility Name (If not institution, ga				Location of Death		4c. County of E	eath	
			8778 Cardinal For 5. Social Security Number 6.	_	yrs. last birthd	Laurel	If Under 24 Hrs.	8. Date of Birth	Howard	Rirthnlace (State	or Foreign
	Funeral Director			1 ☐ M 2 🏋 F	84 Yrs	Months Days	Hours Min.	Aug 18,	1921 Ma	Birthplace (State Country) aine	or r oraigir
	land ow		10a. State 10b. County	10	c. City, Town or	r Location				10d. Inside 0	City Limits
	Many Re-f sh	tor	Maryland Howard	La	aurel					1 🗌 Yes	s 2 🛚 No
	or 28	Direc	10e. Street and Number			10f. Zip Code		100	g. Citizen of What	Country?	
	s 23s	rail	8778 Cardinal For			20723		US			
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event. Ite Medical Examinet must be multiled at once.	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	rin U.S.	<ol> <li>Was Decedent of H If Yes, specify Cuba</li> <li>Yes 2 Xno</li> </ol>	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		merican Indian, /hite, etc.	
21215-0036	72 hou	Completed	15. Decedent's l	Education	16a. De	ecedent's Usual Occup	ation	16	5b. Kind of Busine		
2	vithin ne.	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)		ive kind of work done on the contract of the c	)				
72	Hygier Hygier Ithar ti	S	12 17. Father's Name (First, Middle, Las	<i>t</i> )	Home	emaker	18. Mother's Name		Own Home		
and	d be f	To Be	Frederick Green	,			Mary Loui		20011 0011101109		
Maryland	shou and M s mar umat	-	19a. Informant's Name/Relationship	(Type, Print)	19b. M	ailing Address (Street			City or Town, Stat	e, Zip Code)	
Σ	and 2 saith a n 27 is		Marysue Strong/da			3 Cardinal			rel, MD	20723	
Baltimore,	Pages 1 nent of He ant: If Itan ury or oth		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5 Other (Spec			sposition (Name of crematory or other place ake Cremato	ı		oc. Location - City		and
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Lice	-	C	22. Name and Address Oing Home Beverly L.	Cremation	n Service			21029
ļ.			23a. Part1. Enter the disease, or co- shock, or heart failure. List only	mplications that caused the yone cause on each line.	death. Do not	enter the mode of dyin	g, such as cardiac o	r respiratory arres	t,	Approxima Interval Be	ate atween
	Pnysician	1	Immediate Cause (Final disease or condition resulting in death)	a. Emph	yscin	9				Onset and	
88	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):					1	
	Hart S.	e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	ensequence of):					+	
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c							
68760,	ficate be executed physician and s the burial-transit	ai Ex	resulting in death) Last	Due to (or as a co	ensequence of);						
687	ificate g phys	edicai		0.							
P.O. Box	that the death certifed by the attending detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 20 No 9 Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of Month	,	Year
	res that the signed by th be detache	by Pi	Part II. Other significant conditions	contributing to death but no	ot resulting in th	e underlying cause give	en in Part I.	23e. Did toba	cco use contribut	e to the cause of	death?
ıd	taw requires as been sign 2 should be							1 Yes	2 □ No 3 □	Probably 4	]Unknown
Vital Records,	The ate h	Completed						24a. Was an autopsy performe	prior death		
Vita	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		tions all DOA Othe	26. Place of Death				
of	Phys r this ral dii	.: To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	2 ER/Outpa 28b. Time	tient 3L DOA	4   Nursing Hor	ne 5 XResiden 28d. Describe how		Specify)	
on	nding ath. r: Afte e fune	atlor	1 Xatural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day Ye	ar) Inju		k? Yes 2 □ No				
Division	after deg Director Jin by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			street, factory, office	2	28f. Location (Stre City or Town,	et and Number or State)	Rural Route Nun	nber,
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Medicai C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exc	Physician: To the best of maminer: On the basis of exa and manner stated.	amination and/o	eath occurred at the tin r investigation, in my o	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	se(s) and manner e and place, and o	as stated. due to the cause(	s)
)	To the within	W	29b. Signature and title of certifier	lrup		29c. Licenson	303	No.	d. Date signed (MI	onth, Day, Year) 19 2-00	N
)0	,2		30. Name and address of person who	completed cause of death	(Item 23a) (Ty	pe, Print) PLES ST 70	nison mi	2/201	4		
	Sta Registr		31. Date filed (Month, Day, Year)	2005 32. Regultrar's	Signature	Soul,					
						The state of the s					

			ricase i	State of Manuar				-		
			1 - For State Registrar	State of Marylan		artment of r rtificate of			ZUUJ	39364
		-	Registrar     Decedent's Name (First, Middle, Last)			Timodio oi	Death	2. Date of Death	g. No.	3. Time of Death
	Physici		Reulah	1100	(	ruld		Month No.V.	Day Year 16 2005	4:30 AM
	/Medio Examin		4a. Facility Name (If not institution, give s	treet and number)	0.	4b. City, Town, o	or Location of Death	100 11	c. County of Death	
1	LAGITIII		5800 Main	Street		Que	enstow	10	Queen 1	Anneis
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday		If Under 24 Hrs.	8. Date of Birth	Year) 9. Birth	pplace (State or Foreign untry)
	Director		218-24-2171	M 201 76	Yrs.	World Days	110013	May 19	1929 Ma	ryland
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Cih	, Town or L	ocation				10d. Inside City Limits
	f sho	5	10	1	^	1				1 ☐ Yes 2 PNo
,	28a-	ect	10e. Street and Number	Hnne's (	puee	10f. Zip Code	<i>V</i> )	10	g. Citizen of What Co	into/?
	2 hours after death with the Maryland aturel; or Items 23a or 28a-f show isal Exeminer must be notified at	Funeral Director	5800 Main	Strant	<b>-</b>		658		1150	
	ms 2;	era		2. Was Decedent Ever in U.	S. 13.		Hispanic Origin? (Spe pan, Mexican, Puerto	cify Yes or No-	14. Race - Amer	ican Indian,
9	after or Ite	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No	1	If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, White	, etc.
8	rel', c	l by	3	If Yes, Give Year or Dates:		1 ⊔ Yes 2LLZNo	Specify:		Specify: 1a	CK
21215-0036	C/ 16 34	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occup	pation during most of workind)	ng 1	6b. Kind of Business/l	ndustry
7	within 7. giene. r than "n	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		1			2	( )
	filed v I Hygie other t		17. Father's Name (First, Middle, Last)		Don	1estic	18. Mother's Name			esidence
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Maryland	d 2 should th and Mer 7 Is marke traumatic	2	19a. Informant's Name/Relationship (Typ	DVCWN	19h Maili	na Address (Street		Jane Jane	Heatl City or Town, State, Z	<del></del>
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ē,	s 1 and f Healt item 2 other	1	20a. Method of Disposition	20b. P	lace of Dispo	osition (Name of matory or other pla	0.7(2)	ate 2	0c. Location - City or T	
ě	Pages ment of ant: If it ury or o		1 🗹 Burial 2 □ Cremation 3 □ Re  1 4 □ Donation 5 □ Other (Specify)	movarnom state		inistry of other pla		5/05 6	100 E 0-14 1	le, Maryland
Baltimore	그 돈 돈 글		21. Signature of Funeral Service License		2	Name and Addre	and of Engility			ie, waryand
ä	Depa Impo Impo any it		Janelle	C. Stenry	X <	TIALLIAS	uneralt	STICAN	Ibri Cap. 1	MD.21613
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death	. Do not en	ter the mode of dyi	ng, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
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7	/Medical		resulting in death)	Due to (or as a consequ	uence of):		1			
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	sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertrying Cause (Disease or injury	Dua to (or as a consequ	rance of).	betrut	re Pul	money	N Daga	
	and I-tran	хаш	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):	7517001	7,00		ascase	
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687	icate phys s the		d.					7-4		
Вох (	death certificate e attending phy: id for use as the	/We	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna					23d. Date of deliv	/ACV
-	death a atte	ciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de		]Ectopic pregnanc; ] Other <i>(specify)</i> _	у		Month	Day Year
P.O.	that the deby the detached	Physician/Med	9 Unknown	9□ Unknown						
Ŗ,	The law requires that the ate has been signed by th page 2 should be detache	by P	Part II. Other significant conditions cont	nbuting to death but not resu	ılting in the u	nderlying cause giv	ven în Part I.	23e. Did toba	cco use contribute to	the cause of death?
Records,	w require been sle should b	ed						1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Unknown
၁၁	e law re has be je 2 sho	ompleted						24a. Was an autopsy		opsy findings available
		Con						perform	d? death? No 1 ☐ Yes	
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				26. Place of Death	(Check only one	)	
of \	ys dii	မ	1 □ Yes > No		ER/Outpatier		4   Nursing Hon		ce 6 □Other (Speci	hy)
	ing F	lon:	27. Menner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wai	rk?	28d. Describe how	injury occurred	
isi	Attending is death. sctor: After by the funer	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At ho	me farm st		Yes 2 □No	98f Location /Stre	et and Number or Rur	al Pouta Number
=	lor A after Direct lin by	Certification;	4 Homicide determined	building, etc. (Specify	<i>)</i>	eet, lactory, office	1	City or Town,	State)	si noble ivaliber,
_	Hospital	aic	29a. Certifier Certifying Physi	cien: To the best of my know	wledge, deat	n occurred at the tir	me, date and place, a	and due to the cau	se(s) and manner as	stated.
	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medicel Examin one)	<ul> <li>On the basis of examinat and manner stated.</li> </ul>	ion and/or in	vestigation, in my o	pinion, death occurre	ed at the time, dat	e and place, and due t	o the cause(s)
	To the within To the Comp	W	29b. Signature and title of certifier	2	N	29c. Licens	se number	29e	d. Date signed (Mgnth,	Day, Year)
			· vaune	mamen		H	00210	41	11/21/0	5
			30. Name and address of person who co	pleted cause of death (Item	23a) (Type,	Print) Ce	00576 NKW14	a nd	Contra	1211/2MD
			31. Date filed (Month, Day, Year)	32. Regi <b>e</b> rar's Signat		>4º C	1 11 Willy	Im	, with	21017
T.	Sta Registr			2005	K	Smarth )				

/Medical Examiner

**Physician** 

**Funeral** Director

"natural", or items 23a or 28a-f show ofical Examinar must be notified at Directo Funeral þ Completed the Medical

within 72 hours after Maryland 21215-0036 other than is marked , 1 and 2 st if Health an ittem 27 is Baltimore, permit. Pages 1
Department of H
Important: if its
any injury or ott

death

**Physician** /Medical Examiner

Examiner

Physician/Medical

by

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Certification:

Medicai

certificate be executed attending physician and for use as the burial-trans detached ò signed I been si page 2 certificate Physician: director, After this funeral of within 24 hours after death.

To the Funaral Director: A completely filled in by the fu ö

Box 68760

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Records,

of Vital

Division

8. Date of Birth (Month, Day, Year) 12/28/1916 England 88 217-42-3301 Usual Residence of Decedent 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Chevey Chase Montgomery 10g. Citizen of What Country? 10e. Street and Number 8100 Connecticut 20815 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐ Yo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes XXNo Specify. 3 ₩idowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 4years Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Susanna Shaw Stanley Battye 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Katherine Redel 20901 Hollyberry Court Ashburn, Va. 20147 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 11-29-05 ty☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va Metropolitian Crematory 21 Signatu of Funeral Service Licensee 22. Name and Address of Facility Colonial Funeral Home wall. 201 Edwards Ferry Rd Leesburg, VA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused each line. Immediate Cause (Final disease or condition resulting in death) Probable Drug Overdose Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Due to or as a consequence of Due to (or as a consequence of)

resulting in death) Last

23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 9 Unknown

25. Was case referred to medical

examiner?

4 Homicide

(Check only one)

29b. Signature and title of certifier

0

31. Date filed (Month, Day, Year)

29a, Certifie

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? Yes 2 🗌 No 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) SCENE

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XXYes 2 □ No 27. Manner of Death 1 Natural 5 Pending investigation Accident Suicide 6 Could not be determined

Paga Date of Injury Month, Day Year) 11/22/05

Fire Time of 8:40 A M 28c. injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

Subject ingested drugs 28f. Location (Street and Number of Rural Route Number, City or Town, State) 8101 Connecticut Ave. #717 Chevy Chase, MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Residence

> 29c. License number OCME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) NOVEMBER 23, 2005

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 PENN STREET, BALTIMORE, MARYLAND, 21201

State Registrar

DEC 0 6 2005

N



		1 - State Ragistrar	State of Marylan		artment o		Mental	Hygier Rag. I		39366
		Decedent's Name (First, Middle, Last)						of Death	Day Yeer	3. Time of Death
Physicia			Dorothy M	M. Hol	land		NOVE		21, 2005	5:05 P M
/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Tow	n, or Location of Dea	ath		4c. County of Dea	th
		Crofton Convalesce				Crofton			Anne Ar	
Funeral		5. Social Security Number 6. Sec	144 OF VE	last birthday) Yrs.	If Under 1 Ye Months Da		n. (Mor	of Birth oth, Day, Yea	ar) C	thplace (State or Foreign ountry)
Director		060-16-2133	91	713.			Marc	h 30,	1914 N	ew York
land ow		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
Marylan I-f show	ō	Maryland Prince (	George's		Land	over Hills	S			1 XYes 2 No
n the	Director	10e. Street and Number			10f. Zip Cod			10g. (	Citizen of What C	ountry?
th wit	a D	7105 Taylor Stre	eet		20	784			USA	
r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent If Yes, specify (	of Hispanic Origin? ( Cuban, Mexican, Pue	(Specify Yes	or No- tc.)	14. Race - Am Black, Whi	
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □Yes 2 XNo If Yes, Give		1 □ Yes 2	No Specify:			Specify: W	hite
hour	ed b	15. Decedent's Edu	Year or Dates:	16a. Dece	dent's Usual Oc	cupation		16b.	Kind of Business	
in 72 n na	Completed	(Specify only highest grad	e com <i>pleted)</i>	(Give	kind of work do DO NOT use re	one during most of w tired)	vorking			
with piene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		Homema]	ker			Privat	e
be filed within 72 hours after death with the Maryland tal Hygiene. It hours after death with the Maryland other than 'natural', or items 23a or 28a-f show event, it a Marical Era vir at mast be notified at	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	am <i>e (Fir</i> st, f	Middle, Maid	en Sumame)	
should b ind Menta marked umatic e	10 E	Roy E. Ramsay				Jı	ulia C	ougan		
2 sho and Is ma		19a. Informant's Name/Relationship (T)		1		reet and Number or I				Zip Code)
and lealth m 27 har tr		Thomas A. Holland	(Son)			Road, Je	essup,		0794 Location - City or	Tourn State
Pages 1 nent of H int: If its		20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 ☐ F	telilovat itotti State		osition (Name o matory or other	ž.				
		<ul> <li>4 □Donation 5 □ Other (Specify)</li> <li>21. Signature Funeral Service Ligens</li> </ul>				etery $11/2$			rentwood	
permit. Departrimports Imports any Inju		21. Signature A Puneral Service Citeris	Raylon			napolis Ro				
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Physician	4	Immediate Cause (Final	Pseudomen							Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq		AD COII.	CTO				Days
Examiner			Ulcerativ	e Coli	itis					Years
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying	Due to (or as a conseq							
ecuter	Examiner	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	Artherosc		c Card	ıovascular	r Dise	ase		Years
rate be executed shysician and the burial-transit	Ě	resulting in death) cast	Due to (or as a conseq Diabetes	Melli	tus					Years
cate t	dical		d				-			rears
certifi ding	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy	.,				23d. Date of de	livery
atter for u	clar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1 Live birth 2 □ Feta 4 □ Pregnant at time of d		□Ectopic pregn □ Other (specif)				Month	Day Year
the d	hysi	9 Unknown	9□ Unknown							
s that	by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	inderlying cause	given in Part I.	236	Did tobacc		o the cause of death?
en sig	pa						-	1 🗌 Yes	27€No 3□P	robably 4 Dunknown
law re as be 2 sh	Completed						24a	. Was an autopsy	prior to	utopsy findings available completion of cause of
The ate h	P C						10	performed Yes <del>2/1</del>		s 2 No
cian: eartific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of D				
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ding I	lon	1 √ Natural 5 □ Pending	(Month, Day Year)	Injury		Injury at Work? 1 ∐ Yes 2 ∐ No	200.000	30.100 1.011 11	nary occurred	
Attan deatl ctor: y the	ficat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At h	ome, farm, st			28f. Loca	ation (Street	and Number or R	ural Route Number,
after after d in b	Certification:	4  Homicide determined	building, etc. (Specif	<b>(y</b> )			City	or Town, St	a(e)	
To the Hospital or Attanding Physician: The law requires that the death certific within 24 hours after death.  To the Fundantal Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as			sician: To the best of my kno							
he Ho in 24 he Ft pletel	edical	one)	ner: On the basis of examina and manner stated.	tuon and/of if			curred at the			
Vith To t	Σ	29b. Signature and title of certifier	1	C1		cense number	0	29d. l	Date signed (Mon	th, Day, Year)
10		1 Kakes	r	1		2010	0		11/2/	
16)		30. Name and address of person who can Rakesh Arora,				Lane, Bow	rie M	)		
	ote.	31. Date filed (Month, Day, Year)	32. Registrar's Sign		LIC FOX	Licite, DOW	TG' M			
Sta Registr		NOV 2 2 2005	Land A GO	acts!						

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiepe 05 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** JOHN EDWARD HUGHES 4:43 a November 14, 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5221 Gloucester Road Churchton Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 □ F 87 24, Director 1918 Washington, DC 577-12-1360 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Director Churchton Anne Arundel 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? or Items 23a or 5221 Gloucester Road 20733 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examina 1 XYes 2 □ No 1941— If Yes, Give Year or Dates: 1947 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lieutenant - Fire Department 12 Washington, DC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Edward Hughes Mabel Hilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7704 Telegraph Road, Severn, Maryland 21144 Robert Walker Hughes - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 11/17/2005 \* 4 □ Donation 5 □ Other (Specify) Brentwood, Maryland 21. Signature of Furner I Service License 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate cause (Final disease or condition resulting in death) **Physician** Lymphoma /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner -transit death certificate be executed and Due to (or as a consequence of): burialattending physician Box 68760 Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by Chronic Renal Failure; Diabetes Mellitus 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? 2 X No 1□ Yes 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 📉 No 1 Inpatient 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t Certification: After 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0027189 11.14.05 my. 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Calvert Med. & Prof. Center NA Zahir Yousaf, MD 241人 Solomons Island Road, Huntingtown, Maryland 20639 2 2 2005 32. Registrar's Signature Registra

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	/Medi Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of De	
1	_xaiiii		Garrett County Memorial Hospital Oakland		Car	rrett
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9	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 Is marked other than "natural; or Items 23a or 28a-f show other traumatic event, the Medical Examenatin ust be notified at	臣	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify:	o rican, etc.)	Black, Wi	•
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yla	should be and Mental s marked o	ဥ	Edward Franklin Hoye Mildred	Regi	na Fi	.ke
ar	2 sho and ls ma	n	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru	ıral Route Number,	City or Town, State,	Zip Code)
	1 and 2 Health em 27 l		Catherine R. Hoye/wife 312 E Street, Mountain	n Lake Pa	rk, Md. 2	1550
Baltimore,			20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State	Date 2	20c. Location - City of	r Town, State
Ĕ	permit. Pages Department of I Important: If its any injury or or once.			21/2005	Deer Par	k MD
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m	Dep lmp any	(i)	Stewart Funeral Ho		kland, Md	
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate
. 15	Pnysician		Immediate Cause (Final			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):			10 Urs
	Examiner		Can Noviscoma			10 yrs
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7			Willyan UPau M) · D26650		11-18-	2005
۷.	12		Mulgart affact D 26650  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Make Section 13079 Gawatt his Library California,  31. Date filed (Month, Day, Year)  32. For istrar's Signature	115		
	10		makaiserms 13079 ganott highway calland,	Nd 215	50	
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature			
	Registr	ar	NOV 2 2 2005			

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			For	State of Maryla				Mental Hyg	Phn 5	39369
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13	Physici	an	Decedent's Name (First, Middle, Last	A 1 1 - 4				2. Date of Dea Month	ith Day Year	3. Time of Death
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1/2	Funeral		5. Social Security Number 6. S 186-30-5018	ex 7. Age (in yrs	s. last birthday) Yrs.	Months Day			7, Year) 9. Bi	rthplace (State or Foreign ountry) nsylvania
14.	Director		Usual Residence of Decedent	00				NOV. 24	,1930 Fen	lisylvalita
	land ow		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
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7	r 28e	irec	10e. Street and Number			10f, Zip Code			10g. Citizen of What C	ountry?
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$\mathcal{L}$	dea me	ner	11. Marital Status	12. Was Decedent Ever in I	U.S. 13.	Was Decedent of	Hispanic Origin? (	Specify Yes or No-	14. Race - Am Black, Whi	
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Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging 1 Live birth 2 Fe	tal death 3[	Ectopic pregnan	ісу		23d. Date of de Month	olivery Day Year
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Ē	after after Dire	Certification:	4 Homicide determined	building, etc. (Spec	city)			City or Tow	n, State)	
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	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	nation and/or in	ivestigation, in my	opinion, death occ	curred at the time, o	date and place, and du	e to the cause(s)
	To the within To the COMP	Σ	29b. Signature and title of certifier	10		29c. Lice	nse number	2	29d. Date signed (Mon	th, Day, Year)
			Smuast	J MD		PI	+678		Nov 15	2005
_			30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	Print)			. 1	
				22 S. Grea	ine S	treet	Baltim	me, Mai	yland 2	1201
4-		ate	31. Date filed (Math. 144), 1ea 2	Registrar's Sign	nature	and a		•	(	
1	Regist	rar	***	Later )	V 1670					

State of Maryland / Department of Health and Mental Hygie ( ) 5 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Alice Henderson 0055 M OS /Medical 4a. Facility Name (If not institution, give street and number) County of Death Examiner Allegan aus redmi Source Heart HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. 5. Social Security Number 6. Sex Age (In yrs. last birthday) Aug 1, 1913 Birthplace (State or Foreign County) **Funeral** Days Min. 1 M 2 KF Hours 219-14-7127 92 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-fahov the Medical Examinar must be notified at Mineral Wiley Ford Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō P.O. Box 169 26767 238 USA permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturat", or Items 23a any injury or other traumatic event, tra Maulical Example reserved. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1□Yes 2□No Baltimore, Maryland 21215-0036 ģ Specify: white 3 → Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Edward Rinker Amanda Ambrose Rinker 2 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) P.O. Box 169 WW 26767 19a\_Informant's Name/Relationship (Type, Print)
Coreen Lindsay daughter 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Sunset Memorial Park 12/1/2005 Cumberland MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Nam Staffelli Füneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TIVE PULMONARY DISEAS **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Physician/Medical nding puse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery atten for u 3 □Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) ned by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, should be d þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 4 @Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has birector, page 2 s 1 ☐ Yes 2 No 2 2 No 1 Tes or Attending Physicien: 25. Was case referred to medical examiner?
1 Yes 2 No Medical Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after deeth.

To the Funerel Director: After thi completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 ANatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide o the Hospitel 19 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of codifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Shivc. Khanna, MD 1221 E. National HWY. Cumberland, MD 21502 31. Date filed (Month, Day, Year) 32. Registrar's Signature State DEC 0 6 2005

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmened item #6 per fh/wichd/Certificate of Death11-21-05/d1 Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Doris 0054 Tourde 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Salisbury Wicomico by the Lake 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months -34-85 Director Yrs. Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic averages. 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Wic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. A 21804 Completed by Funeral 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: B) ACK 1 Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR UNKNOWN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) To Be Jartes Miles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mason Dalisbur 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1788urial 2 Cremation 3 Removal from State MAKS U.M. Church Com INCESS AND Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 5 md 2186 54 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 honths? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown certificate has been signed by ector, page 2 should be detact Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 2 No 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autops 1 Yes 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical examinen? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes No Certification: To Inpatient 2 ER/Outpatient 3 DOA this 27. Manner Death
1 Natural
2 Accident ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 1 8 2005

32. Registrar's Signature

Dought Carell, MM 31. Date filed (Month, Day, Year)

			For State Registrar	State of N	Maryland / De C	partment of e <i>rtificate d</i>			al Hygier	CHU	39372
	<b>.</b>		1. Decedent's Name (First, Middle, Las	t)					ite of Death	Day Yea	3. Time of Death
	Physici /Medic		Nona	Hazel	Sheffield	Johnson				17, 200	
	Examin		4a. Facility Name (If not institution, give		•		n, or Location	of Death		c. County of D	
			Prince George's I				everly	04110			George's
п	Funeral Director		5. Social Security Number 6. Social Security Number 1	ox □M 2√2 F / ′	Age (In yrs. last birthda 64 Yrs	Months Da		Min. (M	ite of Birth onth, Day, Yea	9. 6	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		04			Dec	. 9, 1	940	Florida
	nylane how		10a. State 10b. County		10c. City, Town or	Location					10d. Inside City Limits
	Be-f.	cto	Maryland Prince	George's		Lanhar	n				1 X Yes 2 No
	vith th	Director	10e. Street and Number			10f. Zip Cod			10g. (	Citizen of What	Country?
	s 23s		7305 Galileo Way	12. Was Deceder	- Constitute To	2.144 - 22 - 1 - 1	20706			USA	
36	be filed within 72 hours after death with the Maryland ital Hygiene. od other then "naturaf", or Items 23e or 28e-f show svant, the Medical Examiner must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	Armed Force 1 Yes 2 If Yes, Give Year or Dates	s? XNo	3. Was Decedent of If Yes, specify C			es or No- etc.)	Specify:	merican Indian, hite, etc.  Black
21215-0036	2 hou	ted	15. Decedent's Ed		16a. De	cedent's Usual Oc	cupation	. 700.00	16b.	Kind of Busine	
218	within 7 ene. than "n	Completed	(Specify only highest gra Elementary/Secondary (0-12)		life	ve kind of work do . DO NOT use rei	n <i>e during m</i> os tired)	st of working			
	e filed within al Hygiene. other than ' vant, the Me	Con		College (1-40	Tea	cher/Adm				Govern	ment
Maryland	be fill htal H ed ott	Be	17. Father's Name (First, Middle, Last) Monroe Sheffield					er's Name (First		en Sumame)	
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Ma	nd 2 s lith an 27 ls i	6	Leroy A. Johnson			Galilec					a, 2ip Code)
	Hea Hea tem othe		20a. Method of Disposition		20b. Place of Dis	position (Name of	-= 1	Date		Location - City	or Town, State
E O	Pages nent of I int: If it		1 ØBurial 2 ☐ Cremation 3♥ 4 ☐ Donation 5☐ Other (Specify		Forest I	awn /Exer		12/2/200	)5 Pa	nama Ci	ty, Florida
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Fineral S lice Licen	1	/	22. Name and Ad					
<b>m</b>	90 = 50		Menane	1)00	d	9013 Anr	napolis	Road,	Lanham,	MD 20	706
ı.			23a. Part1. Enter the disease, or compensation of the compensation	plications that caus	ed the death. Do not	enter the mode of o	tying, such as	cardiac or resp	ratory arrest,		Approximate Interval Between
H	Physician	4	disease or condition	a . C .	rebra	Vin	ha	relec	on		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence of)!	, ,					
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o,	death certificate be executed e attending physician and of for use as the burial-transit	Еха	resulting in death) Last	Due to to	as a consequence of):	1	2				
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Вох	ath certif attending for use a	Physician/Me	23b. Was decedent pregnant in the past 12 ponths?		2 Fetal death	Ectopic pregna				23d. Date of o	lelivery Day Year
o.	6 ± ë	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4∐Pregnant 9☐ Unknown		□ Other (specify)					,
۵.	that the ed by detac		Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause	given in Part I	1. 23	Be. Did tobacco	use contribute	to the cause of death?
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Vital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place	e of Death Chec		.0	2 110
-	<b>%</b> ≅ ⊕	To	1 Tyes 2 No	Hospital: Inpa	tient 2 ER/Outpat	ent 3 DOA	Other: 4 🗆 Nu	rsing Home 5	Residence	6 □Other (S <sub>i</sub>	oecify)
n O	ing P	iuo!	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Late of Ir (Month, L	njury 28b. Time Da <i>y Year)</i> Injur	of 28c. Ir	jury at Vork?	28d. De	escribe how inj		
sio	ttand death tor: / the f	icat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	Ola Placa of I	niver At home form		□Yes 2□ 		antina (Stant	and blumbor or	Own On the Month
Division	after after Dirac	ertification;	4 ☐ Homicide determined	building,	njury - At home, farm, etc. <i>(Specify)</i>	street, ractory, onto	08	Zei. Lo	ly or Town, Sta	ite)	Rural Route Number,
	spita nours neral	alc	29a. Certifier 1 Certifying Ph	/sician: To the be:	st of my knowledge, de	ath occurred at the	time, date an	nd place, and du	e to the cause(	s) and manner	as stated.
	To the Hospital or Attanding Phymithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	edical	(Check only 2 Medical Examone)	iner: On the basis and manner	of examination and/or	investigation, in m	y opinion, dea	ath occurred at the	ne time, date a	nd place, and d	ue to the cause(s)
	To t To tl	M	29b. Signature and title of certifier			29c. Lice	ense number		29d. D	ate signed (Mo	nth, Day, Year)
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	By		30. Name and address of person who o			e, Print)				/ /	
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	Sta Registr		NOV 2 2 2005	see 10	strar's Signature						

State Registrar 31. Date filed (Month, Day, Year)

NOV 3 0 2005

State of Maryland / Department of Health and Mental Hygiens 0 0 5 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** November 20, 2005 Esther K. Karitas 8:15 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Villa Rosa Nursing Home Lanham Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day Ye
March 25, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral**  Birthplace (State or Foreign Country) Year) 1927 Months 1 ☐ M 2 🕮 F 502-18-7861 Yrs. Director 78 North Dakota Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location in then "naturel", or items 23s or 28s-1 show the Mudical Exeminer must be notified at 10d. Inside City Limits Directo 1X Yes 2 □ No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5623 Westgate Road Funerai 20706 death v USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter c Department of Health and Menta! Hygiene. Importent: If item 27 is marked other than "naturel", or Item any Injury or other treumatic event, if a Mudical Examinations. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Salesperson Private 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Toiro Wattula Hildja Klind 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Karitas (Son) 5623 Westgate Road, Lanham MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Veteran's Cemetery 11/23/2005 Cheltenham, MD 22. Name and Address of Facility Rendon/Hale Funeral Home 21. Signature Fineral Sevice Licenses 9013 Annapolis Road, Lanham MD 20706 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List(only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final **Physician** disease or condition resulting in death) <u>Pneumonia</u> 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in a condition of the condition of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions of the conditions, if any, leading to immediate cause of the conditions, if any, leading to immediate cause of the conditions, if any, leading to immediate cause of the conditions, if any, leading to immediate cause cause of the conditions of the conditi Alzheimers Disease Years Physician/Medical Examiner The law requires that the death certificate be executed ng physician and as the burial-transit Diabetes Mellitus that initiated events resulting in death) Last Years Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ANo Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 2 No 1 Yes 2 X No 1 Tes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: ို 1 ☐ Yes 2 ☑ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA **ACX**Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 01 120108 21/05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, 14300 Gallant Fox Lane, Bowie, MD 20715 M D. 32. Regular's Signature State Registrar

Erica Thanh Knoll 05 - 7359AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item#23a27, 28a-f. perMF C850, 12/7/05 TT

State of Maryland Department of Health and Mental Hygiene O 5

Amend item 8 per fh 281 11-1-16 The State of Death

Reg. No. 1 - For Stete Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 1, 2005 7:17 A M **Physician** Erica Thanh Knoll /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Bowie 13613 Vincent Way If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Mouth Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 □ M 2 1 F Director 215-25-3646 16 11<del>/08</del>/1988 Mary Tand Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28a-f ehow traumatic svent, the Medical Examples must be publical at 1 X Yes 2 □ No Director Maryland | Bowie Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20715 13613 Vincent Way death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status o filed within 72 hours after do I Hygiene.
other than "naturel", or Item Black, White, etc. 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Asian- American à 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) .. Pages 1 and 2 should be filed wi finent of Health and Mental Hygien tent: If item 27 is marked other th jury or other traumatic svent, the 11 Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Nancy Van Le Clifford Henry Knoll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clifford H. Knoll/ Father 13613 Vincent Way Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 11/03/2005 Waldorf, MD Huntt Crematory 21. Signature of Funeral Service 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Difluorerhane Intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner ettending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ Yes 2 ☐ No 24a Was an certificete has 2□No 1 Yes Hospitel or Attending Physician: 24 hours after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) at Scene Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1. Yes 2 □ No 2 his 28a. Date of Injury Fn (Fonth, Day Year) 28c. Injury at Work? 27. Manner of Death Certification; 28b. Time of 28d. Describe how injury occurred UNK 1 Natural 5 Pending 11/1/05 6:30 A investigation 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number of Rural Route Number, City or Town, State) 13613 Vincent Way 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Bowie, MD 24 hours a Scene 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Tymedical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) November 2, 2005 O.C.M.E. pleted cause of death (Item 23a) (Type, Print)
Penn Street, Baltimore, Maryland 21201 3 2005 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygierre 39376 State
Registrar Amend Item #1 Per PHY G850 122/11/11/06 OFIDeath Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Genevieve Audria King **Physician** Year 10:50 A M November 21,2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8736 George Washington Highway Gorman Garrett If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2 🖾 F Yrs. Director 88 220-10-0078 Aug. 26, 1917 West Virginia Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show treumatic event, the Medical Exerterer must be nutified at Director 1 ☐ Yes 2 ☑ No MD Garrett Gorman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 8736 George Washington Highway 21550 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Item any injury or other treumatic event, the Medical Exerci-1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 28 No Specify: White þ Specify: 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Clerk Post Office 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mervin Shambaugh Grace ပ Η. Bosley 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jay Marple/Nephew 1655 Alt House Hill Road, Oakland, Md. 21550 20b. Place of Disposition (Name of cometery, crematory or other place)
Garrett County
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 11/25/05 Oakland, Md. 21550 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 32 S. Second St. Stewart Funeral Home Oakland, Md. 21550 23a. Part1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician weeks Uremia /Medical Due to (or as a consequence of): **Examiner** Renal Failure vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by hypertension 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 No 2 🗀 No Division of Vital 1 Yes 1 TYAS Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 1 Yes 2 X No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Certification: 28d. Describe how injury occurred Injury at Work? After Injury 1 X Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a cal 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D0023979 11/22/2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21550 Robert A. Goralski, М. D. 311 N Fourth St Oakland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** November 29, 2005 Eugene Kline 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 29 East Ave. Hagerstown Washington | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2□F 62 Director 220-40-0681 April 15 1943 Maryland Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits r Iteme 23a or 28a-f show uner must be notified at 1 XYes 2 ☐ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29 East Ave. 21740 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Concrete Finisher Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Kline Rhoda Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important: If Item 27 le eny Injury or other trau Irene E. Kline / Wife 29 East Ave. Hagerstown Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 12/2/2005 Hagerstown, Maryland Rest Haven Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** O months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) the 9□ Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown this certificate has been si ral director, page 2 should Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2□ No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending 1 □Yes 2 □No 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) madon, MC State Registrar

State of Maryland / Department of Health and Mental Hygien 0 5 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Geneva Lee Nov.19,2005 L. 6:42 p.m. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing & Rehab. Clinton Prince Georges If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗓 F 88 Director 231-22-9153 July 27,1917 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location Show 10d. Inside City Limits r than "natural", or Itema 23a or 28a-f showing the Medical Examiner must be notified at 1XXYes 2 □ No D.C. Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3217 12th Place S.E. death v 20032 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify þ Specify: Black 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked ofth any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lloyd O.Edwards Mary L.Bumbray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lori Avant (Granddaughter) 11704 Old Lantern Ct., Ft. Washington, Md. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Mem. 11-26-05 Annandale, Va. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lewis Funeral Home N.Patrick St.,Alex.,Va.22314 Shillips 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Obstructive Pulmonary Immediate Cause (Final disease or condition resulting in death) **Physician** hronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) ivision of Vital Records, P.O. Box 68760. Physician/Medical attending p IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by as been sig 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No has autopsy performed? page certificate 1 Yes 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. М 1 TYes 2 TNo investigation Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title, 29c. License number 29d. Date signed (Month, Day, Year) 0052999 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POAD 205 CLINTON MIAN 7501 SURRATTS 31. Date filed (Month, Day, Year) NOV 2 2 2005 32. Registrar's Sign State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of Maryland		nt of Health and te of Death	Mental Hygier	-000 00010
*	Physici /Medi	cal	Decedent's Name (First, Middle, La:  SUS PINN B      A. Facility Name (If not institution, give)	M. LE	E An Cin	/, Town, or Location of Dea	2. Date of Death Month	3. Time of Death 3. County of Death
*	Examir Funeral Director	ner	Sacred Heart 5 Social Security Number 6. S	HOSpital	Ci	IMPERIOR OF THE STATE OF THE ST	8. Date of Birth	9 Birthplace (State or Streign
	hours after death with the Maryland turel', or Itame 23e or 28e-f ehow al Exactinational by notified at	Director	10a. State 10b. County W. VA. MINE		Town or Location	7		10d. Inside City Limits 1 XYes 2 □ No
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980	ours after d Iral', or itam Exaction	d by Funeral	1 Never Married 2 Married  3 Widowed 4 Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (! ecify Cuban, Mexican, Puel 2 No Specify:	to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Whi TE
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Baltimor	artment o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	) Sc A	22. Name a	Rematory No	U. 26,2005 CRE	ISAPTOWN, MD.
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). );	Pnysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	BINAI	Y Y	CA- METO	Onset and Death  VEHIS
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	The ate h page	Completed by	HYPERCAL	EMIA			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No
Vital	iciar certif recto	Be	25. Was case referred to medical examiner?	Hospital:		Other	ath Check only one	
to	Phys this al dii	2	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 ☐ EF	R/Outpatient 3 D		fome 5 Residence	
Division	Attending Physician: r death. sctor: After this certific: by the funeral director.	Certification:	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day Year)	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	
Div	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determined  29a Certifier 1 Certifying Phy	28e. Place of Injury - At hom building, etc. (Specify)			City or Town, State	, i
	the Hoe hin 24 hi the Fun npletely	edical	(Check only 2 Medical Examone)	rsician: To the best of my knowle iner: On the basis of examination and manner stated.	on and/or investigation	i at the time, date and place i, in my opinion, death occu	e, and due to the cause(s urred at the time, date an	i) and manner as stated. d place, and due to the cause(s)
	To the within to the total	Z	29b. Signature and title of certifier	2-136	11/27/05	c. License number	7 /1	ate stined (Month, Pay, Year)
			30. N me d address of person who d	completed cause of death (Item 2	23 (Typ , Print)	SETTIM	MECICA	KSTATSVE
	Sta Registr		31. Date filed (Month, Day, Yellr)	32. Registrar's Signatur	II) TOO	an jor h	n, LUMB	ENLAND MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Yeer **Physician** 3:20 P M 2005 Thelma Louise Martin November 16. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring
Under 1 Year | If Under 24 Hrs. S1\_\_\_ If Under 1 Year Montgomery Leafy House 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Hours Min. Months 1 ☐ M 2 🕱 F Director 173-20-0413 80 April 30, 1925 Pennsylvania Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Expediment dust be notified at Yes 2 □ No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any injury or other traumatic event, the Modical Expulmer maner and 2006. 10000 Brunswick Avenue Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: **Black** 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contracting Officer Dept. of Defense 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eddie Martin ပ Mary Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beatrice M. Mahaffey/sister 3534 Camp St., Pittsburg, PA 15219 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 11/22/2005 Brentwood, Maryland <sup>22. Name and Address of Facility</sup> Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20722 Approximate Interval Between Onset and Death Immediate Cause (Final ANTERIOSCURUNC CARDIOVARCULAR Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No
9 Unknown 3 DEctopic pregnancy ō Day 4 Pregnant at time of death 5 Other (specify) signed by the at id be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 1 Yes should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed: certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 2 Yes 2□ No 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Pis 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier one

State Registrar

Date filed (Month, Day, Year) 2 2 2005

29b. Signature and title of certifier

32. Registrar's Signature

(OME)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

013234

29d. Date signed (Month, Day, Year)

11/21/05

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	Physic	an	1. Decedent's Name (First, Mi	ddie, Las	t)							2. Date of Dea Month		Year	3. Tim	e of Death
	/Medi				Agn		yers					Novem	ber 21, 2		11:	45P.M.
	Exami	ner	4a. Fecility Name (If not institu	tion, give	street end nu	mber)				4b. City, To	wn, or Lo	ocation of Death	4c. County	y of Death	1	
			S. Carial Carrain Number		e Nursing			If Under	1 Vans		onaco				egany	
	Funeral Director		5. Social Security Number 216-05-5914	6. Se	x ⊐M 2Ď(F	7. Age (In yr. 93	s. last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day	Year)	9. Birth	place (Sta	ite <i>or Foreign</i> and
		1	Usual Residence of Decedent			93						May 26	, 1912		ivial y l	anu
	arylenc	١. ا	10a. State 10b. Cou	nty		10c. C	City, Town or Lo	ocation							10d. Inside	e City Limits
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	ith with the Mar. 23a or 28a-f ab	Director	10e. Street and Number					10f. Zip	Code			1	0g. Citizen of	What Cou	intry?	
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20	urs ef	þ	1 ☐ Never Married 2 ☐ N 3 ☑ Widowed 4 ☐ Divord		1 ☐ Yes If Yes, Gi Year or D	ve '		1□ Yes 2	oN KJS	Specify:			Specif	fy:	Whi	te
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215	c * 6	Jple	(Specify only hig Elementary/Secondary (0-1)		College (	1-4or 5+)	(Give	DO NOT us	rk done se retire	during mos d)	t of work	ing				
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and	be fill d oth avan	Be	17. Father's Name (First, Midd							18. Mothe	er's Name	e (First, Middle, I		•		
ž	d Mer narke	ပ္			ugh Mac	Millan	1						usan Clar			
Maryland 21215-0020	s 1 end 2 should be filed within if Health and Mentai Hygiene. Ifem 27 is marked other than "rother traumatic avent, the Mod	1 4	19a. Informant's Name/Relation			• ,	19b. Maili					al Route Number Road, Midl				
	Heal Heal tern 2		Robert Ma 20a. Method of Disposition	CIVIIII	in-nepnev		Place of Dispo	sition (Nen	ne of		KOCK		20c. Location			
OLL	eges ent of t: If if		1 ⊠ Burial 2 □ Cremation 4 □ Donation 5 □ Other			State	cemetery, cre	matory or of t Memo				November			, Mary	
Baltimore,	permit. Peges 1 end 2 Depertment of Health s Important: If Item 27 is any Injury or other tra once.	H	21. Signature of Funeral Servi									28, 2005				
ä	Deper Impo any Ir		1 c M	K			-	Eich	hhorr			uneal Hom			lain Str	eet,
		H	23a. Part. Enter the disease stock, or heart failure. I	or comp	lications that of	eused the dea	ath. Do not en	ter the mode	e of dyir			ning, Mary		39	Approxir	nate
1	Physician	1	s ock, or heart failure. I	ist only o	ne cause on e	each line.									Interval I	Between nd Death
4	/Medical		Immediate Cause (Final disease or condition		End	stra	Cor	ma	7	Ante	n	In scar		1	yes	25
	Examiner		resulting in death)		a	Due to	(or es e conse	quence of):	(	Q. I	1	018002			J	
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8760,	cete be execu chysician end the buriel-trai	dlcal	cause. Enter Underlying Cause (Disease or injury that initiated events	₹	c	Dura to 1						***				
9	ifficet g phy es the		resulting in death) Last	1		Due to (	or as a conseq	luence of):								
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	deat ed for	sick	Part II. Other significent cond	itlons co	ntributing to de	eath but not re	sulting in the u	nderlying ca	ause giv	en in Part I.		23b. Did to	becco use co	ntribute t	o the caus	se of death?
P.0	thet the ed by th detachs	F.	,									1 □ Y	s 2 No	3 Pro	bably 4	Donknown
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Records,	v requires been sign should be	) je										24a. Was a	n autopsy ned?	av	ere autop: ailable pri ampletion (	sy findings or to
3ec	E 8 S	훁	,											of	death?	n cause
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of Vital	Physicien: The this certificete ral director, pag	Be	25. Was case referred to med examiner?	-	Hospital:				Oth			(Check only on				
ð		٦.	1 ☐ Yes 2 ☒ No  27. Manper of Death		28a. Date	of Injury	ER/Outpatier 28b. Time o		Bc. Injur	vat		me 5 🗆 Reside 28d. Describe ho			fy)	
ion	Attending ir death. ector: After by the fune	ij	T Natural 5 □ Pen 2 Accident inve	ding stigation	(Mon	th, Day Year)	Injury	м	Bc. Injur Wor 1 □	k? Yes 2∐t			,,			
Division	Atter ector by th	III	3 ☐ Suicide 6 ☐ Cou	ld not be mined	28e. Place	of Injury - At I	home, farm, str	reet, factory,	, office			28f. Location (St		per or Run	a <i>l R</i> oute N	u <i>mber</i> ,
Ö	tal or rs effe ai Dir led in	Certification:	4 E Homode		Dullai	rig, etc. (Spec	ary)					City or Town	, State)			
	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the fun	edical	Check only 21 Medic	ying Phy al Exemi	sicien: To the	best of my kn	owledge, death	n occurred a	t the tir	ne, date and	d place, a	and due to the ca	use(s) and ma	anner as s	stated.	e(s)
	thin 2 the 1 mplet	Med	one) 29b. Signature and title of cert		and man	ner stated.										
	5 ≥ 5 S		205. Signature and title of cent							e number			9d. Date signe			,
			30. Name and address of pers	- T	ampleted	on of closest 11:	m 02-1 /T	Drint'	0 =	2124	14		11/2:	2/0	5	
	4		Jesus H. 7		_	3	mi∠oa)(Type,	FIRSTA	Suca	mi	0	21532				
	Sta	ite	31. Date filed (Month, Day, Ye	ar)	32. F	ROADW Signistrar's Sign	nature		9,	,						
	Registr	ar	MOV	287	11115	200	ME .	Tracks.	9							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiepten Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER 23 **Physician** 2005 3:00 AM WILLIS D. MOYER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT 107 GRACE STREET ST. MICHAELS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth MAY 23, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 81 Yrs. 165-24-0676 PA Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State rai', or items 23a or 28a-f show Examiner must be nutition at X Yes 2 No Director MD TALBOT ST. MICHAELS 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 21663 USA 107 GRACE STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after \_**X**es 2 □ No Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 natural', or 1 ☐ Yes 2X No Specify: WHITE ò Specify: 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) CORRUGATED BOX other than Elementary/Secondary (0-12) College (1-4or 5+) 12 4 SALESMAN MANUFACTURING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental is marked B. WILLIS MOYER CASSANDRA DURGIN ೭ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 nt of Health a PO BOX 578, ST. MICHAELS, MD 21663 LOIS H. MOYER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or CHESAPEAKE CREMATION CTR 11/23/2005 STEVENSVILLE, MD A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHNT. MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nset and Death Immediate Cause (Final disease or condition Cancer Physician ear resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical the the attending USB 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.0. detached 9 Unknown 9 Unknown signed by i 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. 1 Yes 2 🗌 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 PNo Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 2 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Mann of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certification: After Attending 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 124 hou. 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. the within To the 29d. Date sigfled (Month, Pay, Year) 29c. License number 29b. Signature and title of certifier 2 98 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID SMITH M.D. 29466 PINTAIL DRIVE EASTON, MD 21601 BY 31. Date file NOVh, PaySYe2005 32. Registrar's Signature State Registrar

		-		eartment of Health and Me ertificate of Death	ental Hygien Reg. No	000 03000
	Physicia	an	1. Decedent's Name (First, Middle, Last)  Delmas Woodroe Marshall		2. Date of Death Month November	3. Time of Death 15, 2005 9:03 P M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	40	c. County of Death
	Funeral		47311 Lincoln Avenue  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday	Lexington Park    If Under 1 Year   If Under 24 Hrs.	3. Date of Birth	St. Mary's  9. Birthplace (State or Foreign Country)
	Director		214-48 7754 1 <sup>1</sup> Ø 2□F 56 Yrs.	Months Days Hours Min.	une 3, 19	49 Virginia
	yland now		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation		10d. Inside City Limits
	he Mar 8a-f s	ector		ton Park	10.0	1 ☐ Yes ¾☐ No
	3a or 3	Dir	47311 Lincoln Avenue	10f. Zip Code 20653	10g. C	itizen of What Country? USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or othar traumatic evant, the Medical Examinar must be notified at once.	by Funeral Director	1 ☐ Never Married 2 █ Married 1 ☐ Yes 2 █ No ☐ If Yes, Give	Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.
00-10	2 hour natural ical Ex	ted b	15. Decedent's Education 16a, Dece	edent's Usual Occupation	16b. i	White Kind of Business/Industry
Maryland 21215-0036	d within 7 giene. er than "r	Completed	Elementary/Secondary (0-12)   College (1-4or 5+)	e kind of work done during most of working DO NOT use retired) Foreman		blic Works
and	d be file intal Hy ed oth	Be	17. Father's Name (First, Middle, Last) Homer Woodrow Marshall	18. Mother's Name (		n Sumame)
ary	and Me and Me is mark	P		ling Address (Street and Number or Rural		or Town, State, Zip Code)
	1 and 2 Health em 27 I	1	Karen L. Marshall - Wife 1431  20a. Method of Disposition 20b. Place of Disp	1 Lincoln Avenue, L		Park, MD 20653  Location - City or Town, State
mor	Pages nent of nt: If it		Labural 2 Cientation 3 Chemoval from State	position (Name of ematory or other place) 11-22	/-115	holsville, VA
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee M00053		. 0. box :	
	4		23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):		-	
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	notive pulmonam	disease	
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.			
68760,	ificate be executed g physicien and as the burial-transit		resulting in death) Last Due to (or as a consequence of):			
		Aedicai	d.			
O. Box	The law requires that the death cert ate has been signed by the attending page 2 should be detached for use a	Physician/M		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
<u> </u>	w requires that the de been signed by the a should be detached f	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
Division of Vital Records,		Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vita	Physician: Th this certificate ral director, pag	o Be (	25. Was case referred to medical examiner?  Hospital:	26. Place of Death (		
οľ	g Physter this	<b>—</b>	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c, Injury at 28	e 5 Residence d. Describe how inju	6 □Other (Specify) ury occurred
isior	ttendin death. stor: Af	icatic	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	If Location (Street a	nd Number or Rural Route Number,
Ω	s after al Direct	Certification:	4 Homicide determined building, etc. (Specify)	treet, ractory, office	City or Town, Stat	e)
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funaral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, deal control of my knowledge, deal contro	ith occurred at the time, date and place, an nvestigation, in my opinion, death occurred	d due to the cause(s d at the time, date an	s) and manner as stated. Ind place, and due to the cause(s)
	To the within 2. To the I complet	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Dey, Year)
0			30. Name and address of person who completed cause of death (Item 23a) (Type	D22574	mo 1	1116102
1	B7		Dr. Robert T. Pace, MD, 12070 01d Li	ne Center, Suite 30	2, Waldor	f, MD 20604
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 8 2005	Sparke		

			1 - For State Registrar	State of M	aryland	d / Depai <i>Cert</i>	rtmen tificat	t of H e of L	ealth a Death		F	Reg. No.	005	39384	_
	Physici /Medio		1. Decedent's Name (First, Middle, La Isabella Mari								Date of Dea Month	er Day	19,20	05 2:20a <sup>M</sup>	Λ
	Examir	er	4a. Facility Name (If not institution, given 122 Layfette				E1k	ton	Location of				County of De	ath	
	Funeral Director		160-24-8877	Sex 7. Ag 1 □ M 2 □ ★F	e (In yrs. Ia 74	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birt (Month, Da) arch	y, Year)	(	irthplace (State or Foreig Country) PA	in
	aryland show	<u>_</u>	Usual Residence of Decedent  10a. State  10b. County			, Town or Loca	ation							10d. Inside City Limits  X□ Yes 2 □ No	
	h the M or 28a-f	Director	MD Ceci	1	Ell	kton	10f. Zip	Code				10g. Citiz	en of What (	Country?	
<b>'</b> 0	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: if Item 27 is marked other than "natural", or Items 23e or 28e-f show injury or other traumatic event, the Medical Examiner roual be ricitlised at injury or each other traumatic event, the Medical Examiner roual be ricitlised at 8e.	Funeral D	122 Layfette 11. Marital Status 1 Never Married 2 XMarried	12. Was Decedent Armed Forces? 1 ☐ Yes 2 €					spanic Orig n, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	. 1		S • A • nerican Indian, nite, etc.	
0036	hours a tural', or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		16a. Decede	Yes		Specify:				Specify: and of Busines	White	_
Maryland 21215-0036	within 72 ane. than nat	Completed	(Specify only highest gr		5+)	(Give k. life. De	ind of wor O NOT us	rk done a se retir <b>e</b> d,	luring most )	of working			edica.	•	
nd 2	be filed ital Hygie of other	Be Co	17. Father's Name (First, Middle, Las	")			. I SC	JA		's Name (i	First, Middle,			<u>L</u>	
Ŋ	should but and Ment	2	Herman Joseph 19a. Informant's Name/Relationship			19b. Mailing	Address	(Street a					ridge Town, State		_
	and 2 s salth an n 27 ls		Lawrence Murp		nd	020200		3-12002				F6-993-00		921 or Town, State	
nore	Pages 1 nent of He ent: If Iten ury or oth		20a. Method of Disposition  M☐ Burial 2 ☐ Cremation 3		Ce	emetery, crema	atory or o	ther place	<sup>∌)</sup> Nc	veml	er 2	8,			
Baltimore,	permit. Pages Department of Important: If I any injury or once.		*4 □ Donation 5 □ Other (Special 21. Sign rura of Ferroral Service Lice	•	ELF			d Addres	s of Facility		neral		E <u>lkto</u> ne	n, MD	
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that cause one cause on each l	d the death.	. Do not enter	f the mod	Mo of dying	ain S	erdiac or r	E1kte espiratory ar	on,	MD :	2 1 0 2 1 ximate Interval Between	
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Reno		Carcer Jence of):	nom	a w	ith sp	insl	meta.	stosi.	5	Onset and Death	
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3760,	ate be executed rysician and he burial-transit	icai	resulting in death) Last	Due to (or as	a consequ	ence of):									
.O. Box 68	that the death certificat led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3 □E	Ectopic pr Other <i>(sp</i>					23	3d. Date of d Month	elivery Day Year	
Δ.	jures that n signed b	ρ	Part II. Other significant conditions	contributing to death t	out not resu	Iting in the und	derlying c	ause give	en in Part I.					to the cause of death?  Probably Unknown	٦
Division of Vital Records,	: The law requires that cate has been signed by page 2 should be deta	Completed											24b. Were a prior to death?		В
Vita Vita	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?  1  Yes  2 No	Hospital:	ent 2 🗆 E	ER/Outpatient	3□ DC	Othe	ar-	of Death (	Check only o		□Other (Sp	necify)	
on of	ding 7. After fune	ation; T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	iry y Year)	28b. Time of Injury	M 2	8c. Injury Work		28	d. Describe h			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Divis	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	28e. Place of in	jury - At hor c. (Specify,	me, larm, strei	et, factory	, office		28	f. Location (S City or Tow		Number or I	Rural Route Number,	
	Hospital or 24 hours afte Funeral Dir stely filled in	edical	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best miner: On the basis of and manner si	if examinati	wledge, death ion and/or inve	occurred estigation	at the tim , in my op	e, date and pinion, death	place, and occurred	due to the d at the time, d	cause(s) a date and p	and manner a place, and di	as stated. ue to the cause(s)	
	To the within 2 To the comple	Med	29b. Signature and title of certifier	100 ·				: License				29d. Date	signed (Moi	nth, Day, Year)	_
	1		annik de	Chene	m	00a) (Tu D			5990				21-05		
	5		30. Name and address of person who	lain 16	H E	Z3a) (Type, P	rint)	Ave	. N	oth	East	M	0 21	901	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	23a) (Type, P									

			1 - For State Registrar	State of Ma		artment of Hertificate of E	ealth and Men Death	ntal Hygien		39385
			1. Decedent's Name (First, Middle, La	est)				Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		William Raymo	nd McCar	thv			vembe		5 8:00p M
	Examir		4a. Facility Name (If not institution, gir		•	4b. City, Town, or	Location of Death		4c. County of Death	
			212 Market St			Charles			Ceci1	
	Funeral			Sex 7. Ag 1-Q∃M 2. ☐ F	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8. [ Hours Min.	Date of Birth Month, Day, Ye	ar) Cou	place (State or Foreign
	Director		215-58-1436	X 20 F	54 Yrs.		Ju	ne 5,1	1951 NY	
	pug ≱_		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	deryte aho	៦	MD Cecil		-					1 Yes 2 No
	the A	ect	10e. Street and Number		Charle	10f. Zip Code		100	Citizen of What Cou	
	with	ᡖ	20 TO 50 to 500			2191	Λ			nityt
	effer deeth with the Meryland or Itama 23s or 28s-1 show inclinet must be notified at	era	212 MarketSt.  11. Marital Status	12. Was Decedent	Ever in U.S. 13				S · A ·	can Indian
40		듩	1 ☐ Never Married 2 ☐ Married	Armed Forces?	No.	f Yes, specify Cubar	panic Origin? (Specify , Mexican, Puerto Rica	n, etc.)	Black, White,	
38		þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠No	Specify:		Specify: W	hite
5-0036	72 hours "natural", szlical Ex	Completed by Funeral Director	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupa	tion	16b	. Kind of Business/In	dustry
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2121	od within rgiene. er then	5	12			enance			Hote1	
	s t and 2 should be filed v t Heelth and Mental Hygis Itam 27 Is marked other i other traumatic event, IL	Be	17. Father's Name (First, Middle, Last	"			18. Mother's Name (Fir	rst, Middle, Maid	len Sumame)	
Maryland	should be nd Mental marked maric ev	၉	Thomas L. McC	arthy, S	r		Evelyn K	ato		
a	2 shc and lama	2 3	19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street ar	nd Number or Rural Ro	ute Number, Cit	y or Town, State, Zip	Code)
-	and and m 27		Thomas McCarth	y Jr./So		S. Col.	lege Ave.	. Newa	rk, DE	19702
ore	of Hee		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	cemetery, crei	sition (Name of natory or other place	Novemb	er, 200.	Location - City or To	own, State
Ē	Peg ment ant: ury		`4 □ Donation 5 □ Other (Speci		R.A. Fe	erris, I	nc.21,200		est Ches	ster,PA
Baltimore	permit. Peges Depertment of I Important: If its any injury or o		21. Signature of Funeral Service Lice	nsee		Name and Address	of Facility • Gee Fun	oral U	omo	
	00 = 0		23a. Part1. Enter the disease, or com							021
			snock, or neart failure. List only	plications that caused one cause on each li	I the death. Do not ent ne.	er the mode of dying	, such as cardiac of res	piratory arrest,	, 110 49	Interval Between Onset and Death
M	Pnysician	8 3	Immediate Cause (Final disease or condition	a. auto	my scerd	Frequent	<del>)</del> د			Chiser and Death
1	/Medical Examiner		resulting in death)	Due to (or as	a cons quence of):					
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Box (	leeth certifice ettending ph i for use es t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d. Date of delive	arv
m	deeth e etter ed for u	clar	in the past 12 months?	1☐Live birth 4☐Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
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<u>α</u>	res that the deett Igned by the ette be deteched for		Part II. Other significant conditions	contributing to death b	ut not resulting in the u	nderlying cause giver	n in Part I.	23e. Did tobacc	o use contribute to th	ne cause of death?
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tal	ilcian: Th certificete rector, peg	0	25. Was case referred to medical	<u> </u>		<del></del>	26. Place of Death (Ch	1 Yes 2	No 1 ☐ Yes	2 L No
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	To the Mospital or Attandl within 24 hours efter deeth. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	nysician: To the best	of my knowledge, death	occurred at the time	, date and place, and o	the time date of	(s) and manner as st	ated.
	tha h	Medical	one)	and manner sta	ited.					` '
	5 ¥ 5 ₽	2	29b. Signature and title of certifier			29c. License			Date signed (Month,	
			I Am cee 140	Z-MD		DO	t023	11	118/05	
	4		30. Name and address of person who			Print)	4	1 -4	FIRE	-Md 2192)
	1		31. Date filed (Month, Day, Year)	HSU M		-23 W4	or ma	n st	917	-1 2-112
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		For Stata Registrar	State of Marylan				ealth an Death	nd Men		ene g. No.	005	39386
		1. Decedent's Name (First, Middle, Last	)						Date of Death	Day	Vaar	3. Time of Death
Physic		Laura Catherine O	'Neal						Month Ovember		2005	0743 4
/Med Exami		4a. Facility Name (If not institution, give	street and number)		4b. City	Town, or	Location of D	Death		4c. Co	unty of Death	
		Peninsula Region	al Medical Ce	nter	Sa	lisb	0 F 4			Wi	comic	0
Funera		5. Social Security Number 9 6. Se	7. Age (In yrs.	last birthday)		r 1 Year	If Under 24		Date of Birth		9. Birtho	lace (State or Foreign
Director		221-18-1231	<sup>™ 2⊠F</sup> 76	Yrs.				Se	Month, Day, pt. 9,	1929	Dela	
pu *		Usual Residence of Decedent  10a. State 10b. County	10c Cit	y, Town or Lo	ocation						1	0d. Inside City Limits
anyla •ho	5		_	ast Ne		rket						1 XYes 2 □ No
the N	Directo	Maryland Dorchest	er	ast NC		p Code			10	n Citizen	of What Cour	ntry?
with a or	급	-2.	a			1631				USA		, .
hours after death with the Maryland tural', or Iteme 23a or 28e-f show at Examinar must be notified at	Funeral	5946 Heritage Roa	12. Was Decedent Ever in U	.S. 13.			spanic Origin n, Mexican, F	n? (Specify	Yes or No-		Race - Americ	ean Indian,
fier d	Fun	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes 2 🔯 No					Puerto Rica	in, etc.)		Black, White,	etc.
urs a	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2⊠ No	Specify:			Sp	ecify:	White
2 ho	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece	dent's Us	al Occupa	ation during most of	f working	1	6b. Kind	of Business/In	dustry
within 72 ene. then nel	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	ise retired	)	, working				
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2 sh and ie m		19a. Informant's Name/Relationship (T			-					-	own, State, Zip	(Code)
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t. Partmer		4 Donation 5 Other (Specify,		yland				/21/2			h, Mary	/Iand
Datumore, Marylar part permit. Pages 1 and 2 should be Department of Health and Menta Important: if Item 27 is marked each tolyury or other traumatic ences.		21. Signature of Fund al Service Licente	Selle	Ź	elle ast	r Fur	eral H larket,	Home,	P. O.	Box	207	
TOTAL STORY		23a Part1. Filter the disease, or composhor, or heart failure. List only of	lic trions that of used the deal	h. Do not en	ter the mo	de of dyin	g, such as ca	ardiac or re	spiratory arre	est,		Approximate Interval Between
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		30. Name and address of person who	pleted cause of death (Ite	m 23a) (Tune	Print\	טט(	,	U		. [[		
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiepe 05 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER Day 18, 2005 9:15 am **Physician** POWELL INDIANA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HOLY CROSS HOME CARE & HOSPICE MONTGOMERY CO. SILVER SPRING 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10-06-1911 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 1□ M 2 F DINWIDDIE, VA. 218-20-2035 Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 906 10th STREET, NE 20002 U.S.A. 238 Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: BLACK 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 7 t h College (1-4or 5+) MAINTENANCE WORKER other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fite Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 9068: ANDREW JOHNSON ROSE ANNA RICHARDSON JAMES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20020 LINDA D. POWELL - DAUGHTER 2330 GOOD HOPE ROAD, SE #1120 WASH. DC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MD NATIONAL MEM.PK11-26-05 4 ☐ Donation 5 ☐ Other (Specify) LAUREL, MARYLAND 21. Signature of Funeral Service Ligen 22. Name and Address of Facility TAYLOR 'S FUNERAL HOME 1722 NORTH CAPITOL ST., NW WASH.DC 20001 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner PULMONARY HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes X No 24a Was an autopsy rmed? 22 No 1 Yes Be 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 XNatural s after deau.
ral Director: Aftr 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 62571 NOVEMBER 18, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. BROMELAND - 1500 FOREST GLEN RD., SILVER SPRING, MD 20910 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 2 2 2005 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year James Parker November 19. 2005 6:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6801 Bock Road #359 Prince George's Ft. Washington If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 579-48-5936 1**X**XM 2□ F Director Yrs. June 6. 1933 Washington, DC Usual Residence of Decedent the Maryland 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 77 is marked other than "neturel", or Items 23a or 28a-1 show treumetic event, the Madral Examiter must be multiple at 1 ☐ Yes XX No Maryland Prince George's Ft. Washington Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6801 Bock Road #359 20744 USA death 12. Was Decedent Ever in U.S. Armed Forces?

1XXX Yes 2 □ No 1953—
If Yes, Give Year or Dates: 1955 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ^by 1 ☐ Yes 2 XXNo Specify 3 XXVidowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Protective Officer 12th Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Joseph Parker Julia Dudley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heidi Parker-Slaughter/Daughter 3512 Silver Park Drive Apt.5 Suitland, MD. 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State txxBurial 2 ☐ Cremation 3 ☐ Removal from State <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Quantico Nat. Cemetery 11/29/05 Quantico, Virginia 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or injury certificate be executed use as the burial-transit that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death P.O. I 5 Other (specify) 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2XXVo 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death Check onl one examiner Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 0 1 Tes 2xxNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After Hospital or Attending 1 XXNatural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1XXCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 11/21/05 30. Name and address of person wh who completed cause of death (Item 23a) (Type, Print) 6104 Old bya 2005 Registrar

Discrete Processor Name affect Messay Learn of Common Comm		Sta Registra		Bahram Pishdad, Nov. Pate filed (Month, Day, Year)	ID 1328 Sout		nue, Room	310, Was	hington	, D.C.	2003	2
Dispetation in Decedent Name (Finish Missins, Last)  MARCELLE PURKELL  MARCELLE PURKELL  Sacred Heart Home  Sacred Heart Home  Sourced George 's November 18, 2005 8:45 p. M. November 18, 200							Print)					
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Physician Marcelle Punnell  Physician Marcelle Punnell  Sacred Heart Home  Sacred Home  Sacred Home  Sacred Heart Home  Sacred Home  Sa		v requires that been signed b	by				derlying cause given	in Part I.	1 🗆 Yes	2 □ No	3 🗌 Proba	bly 4 🛣 Unknown
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Physician Marcelle Purnell  Sacred Heart Home  Funeral Director  Page No.  1. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  4a. Facility Name (If not institution, give street and number)  Sacred Heart Home  S. Social Security Number  6. Sex  1	Baltim	permit. Pag Department Importent: i any injury o		`4 □Donation 5 □Other (Special	y) I	22	. Name and Address	of Facility Gas	ch's Fun	eral H	ome,	P.A.
Physician Marcelle Purnell  Sacred Heart Home  Funeral Director  Page No.  1. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  4a. Facility Name (If not institution, give street and number)  Sacred Heart Home  S. Social Security Number  6. Sex  1	ore, N	es 1 and of Health I item 27 r other tr		20a. Method of Disposition	2	9563  Ob. Place of Disponentery, crem	Fort Foot sition (Name of natory or other place)	e Road,				
Physician Marcelle Purnell  Sacred Heart Home  Funeral Director  Page No.  1. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  4a. Facility Name (If not institution, give street and number)  Sacred Heart Home  S. Social Security Number  6. Sex  1	laryle	2 should and Mer is mark eumatic	၉		Type, Print)	19b. Mailin				City or Town,	State, Zip	Code)
Physician /Medical Examiner  I. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  4a. Facility Name (If not institution, give street and number)  Sacred Heart Home  Funeral Director  Funeral Director  Maryland Prince George's  Fort Washington  10a. State  10b. County  Maryland Prince George's  Fort Washington  10c. City, Town or Location  Maryland Prince George's  Fort Washington  10d. Inside City Limits  10d.	and	~ - 0 %	Be	, , ,	)	30010		8. Mother's Name	(First, Middle, M			
Physician /Medical Examiner  I. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  4a. Facility Name (If not institution, give street and number)  Sacred Heart Home  Funeral Director  Funeral Director  Maryland Prince George's  Fort Washington  10a. State  10b. County  Maryland Prince George's  Fort Washington  10c. City, Town or Location  Maryland Prince George's  Fort Washington  10d. Inside City Limits  10d.	121	within iene. than	emple					ing most of working	(			
Physician /Medical Examiner  A Facility Name (If not institution, give street and number)  Sacred Heart Home  Social Security Number  5. Social Security Number  Social Securi	5-0036	72 hours after natural', or its	ρ	3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	16a, Deced	Yes 2 No	Specify:	1	Specify	Whi	te
Physician /Medical Examiner  A Facility Name (If not institution, give street and number)  Sacred Heart Home  Social Security Number  5. Social Security Number  Social Securi		death v	neral		12. Was Decedent Ever	in U.S. 13. V		panic Origin? (Spe	cify Yes or No-	14. Rac	e - Americ	
Physician /Medical Examiner  A Facility Name (If not institution, give street and number)  Sacred Heart Home  Social Security Number  5. Social Security Number  Social Securi		vith the	Direc	10e. Street and Number					10	g. Citizen of V	Vhat Coun	try?
Physician /Medical Examiner  A Facility Name (If not institution, give street and number)  Sacred Heart Home  Social Security Number  5. Social Security Number  Social Securi		Maryla	tor								110	od. Inside City Limits 1 XYes 2 □ No
Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  4a. Facility Name (If not institution, give street and number)  Sacred Heart Home  1. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  4a. Facility Name (If not institution, give street and number)  Sacred Heart Home  4b. City, Town, or Location of Death  Hyattsville  Prince George's  Funeral  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  Month Day  (Country Near)  Country Month Day  Country Near  (Country Near)  Month Day  Month Day  Month Day  Month Day  Country Near  (Country Near)  Month Day  Month Day  Month Day  Month Day  Month Day  Countr		ס		Usual Residence of Decedent					Jan. 20	<b>,</b> 1920		
Physician //Medical Examiner  1. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  4a. Facility Name (If not institution, give street and number)  Certificate of Death Month Day Year November 18, 2005 8:45 p  4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death				5. Social Security Number 6. S	Sex 7. Age (In		If Under 1 Year	If Under 24 Hrs.	(Month Day	Year)	9. Birthpl Coun	ace (State or Foreign try)
Physician  1. Decedent's Name (First, Middle, Last)  MARCELLE PURNELL  2. Date of Death Month Day Year New Year								ocation of Death		4c. County	of Death	
Registrar Certificate of Death Reg. No.									Month	Day		
State of Maryland / Department of Health and Mental Hygiene 0 0 5 3 9 3 8 9						Cei	tificate of D	eath	Re	g. No.	C	39389

State of Maryland / Department of Health and Mental Hygiepe 05 39390 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Sophie 13, 2005 Pohutsky November 12:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care Wheaton Wheaton Montgomery If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Month Day Year) 10/20/1932 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F 201-24-9362 73 Director Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other then "neturel", or items 23e or 28e-f show treumetic event, it e Madical Examiner must be notified at 1 ☐ Yes 21 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1135 University Blvd W. 20902 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 Yes, Give 2**№** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: White ρ Specify 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if Item 27 is marked other then 'any injury or other treumetic event, Item. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pohutsky Unknown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stanley Pohutsky - Cousin 11408 Lund Place; Kensington MD 20895 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State Fort Lincoln Crematory 11/20/2005 \* 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home Myelin T. Wlobert 11800 New Hampshire Ave.; Silver Spring MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Pancreatic Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal Failure 1 Tes 2√ No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? Diabetes Mellitus 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🛂 No 1 ☐ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ₹ No Certification: To Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 🙀 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a 29c. License number 29d. Date signed (Month, Day, Year) D58962 11/16/2005 ress of person who completed cause of comments and (Type, Print) Shashank Patel M.D. 2309 Shorefied Road; Wheaton Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 18 2005 Registrar

			1 - For State Registrar	State of Maryl	and / Depa	artment of rtificate o	Health and f Death		ene 0 0 5	39391		
	Physici /Medio	cal	1. Decedent's Name (First, Middle, Las  LOIS HORNER PUSEY					2. Date of Death Month November	Day Year	1,000		
	Examir Funeral Director	ner	4a. Facility Name (If not institution, give Peninsula Region 5. Social Security Number 212-09-2173	nal Medical 7. Age (In )	Center yrs. last birthday) 00 Yrs.			S. 8. Date of Birth	4c. County of Dea  Wicom  (ear)  9. Bir  Ca  15  PEN			
	<b>D</b>	tor	Usual Residence of Decedent  10a. State 10b. County  MD WICOMI	10c.	City, Town or Lo			100-13-19	15 TEN	10d. Inside City Limits 1 ☑Yes 2 ☐ No		
	h with the 23a or 28e	Funeral Director	10e. Street and Number 200 CIVIC AVENUE			10f. Zip Code	21804	10g	. Citizen of What Co	puntry?		
036	n 72 hours after deeth with the Maryland "neturel", or Iteme 23a or 28e-f ehow edical Examinat must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces?  1  Yes 2 No lif Yes, Give Year or Dates:		Was Decedent of If Yes, specify Co 1 ☐ Yes 🎉 N	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or No- nto Rican, etc.)	14. Race - Ame Black, Whit Specify: W			
Maryland 21215-0036	filed within 72 h Hygiene. other then "netu ent, tre Wedicel	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 1 1	ucation de completed) College (1-4or 5+)	(Give	dent's Usual Occ kind of work dor DO NOT use ret EAMSTRES	ne during most of wo ired)	orking	b. Kind of Business SHIRT FAC			
ryland	ag is b ≥	To Be	17. Father's Name (First, Middle, Last)  IRA HORNER  19a. Informant's Name/Relationship (T	ivos Print)	10b Maili	no Address /Ctra	ALICE I	me (First, Middle, Ma FOSKEY Jural Route Number, C		7- 0-1-1		
	1 end 2 Health a em 27 le ther tra		THOMAS H. PUSEY,	III - SON	1309	EMERSON	AVENUE,	SALISBURY,		21801		
Baltimore,	permit. Peges Department of Important: If It any Injury or o		1 NBurial 2 Cremation 3 1 4 Donation 5 Other (Specify 21. Signature of Funeral Sarvice Licent	)  H1	EBRON CE	METERY  2. Name and Add	11-2 dress of Facility B(	20-2005 HE DUNDS FUNE EET.SALISB	RAL HOME,			
	Physician /Medical Examiner		23a. Part. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lication that ceused the dine cause on each line.  a. ACUTE  Due to (or as a con	MyoC	er the mode of d	tying, such as cardia			Approximate Interval Between Onset and Death		
8/60,	certificate be executed uning physicien and ise as the burial-transit	dicai Examiner	d									
.C. BOX 6	death e atter id for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnar Other (specify)			23d. Date of dea Month	ivery Day Year		
rds, r	requires that the een signed by th hould be detache	ρ	Part II. Other significant conditions co	STENO.	212	nderlying cause	given in Part I.			the cause of death?		
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אווע זס ר	ding Physicien: n. After this certific funeral director,	n: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	2 ER/Outpatien 28b. Time of	JU DON	Other: 4 Nursing F	ath (Check only one)  Home 5 Residence 28d. Describe how		cufy)		
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	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	one)	rsician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death	vestigation, in my	y opinion, death occu	urred at the time, date	and place, and due	to the cause(s)		
,	Son Sign	×	29b. Signature and title of certifier  30. Name and address of person who c	ompleted cause of death /	1 M.	D 29c. Lice	> 46	962 N	Date signed (Month	T. Dey, Year)  ER 17, 2005		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature		FIONAL	MEDICA	L CENT	ER. MD 21801		
	Registr	-	NOV 182	UUD Bonn	H A							

			For	State of M		d / Depa	artment	of H	ealth a				nns	3939	2
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Н	Physicia	an	Decedent's Name (First, Middle,								2. Date of Di Month	eath Day	Year	3. Time of De 1:10 p	
	/Medic Examin		Ann Marie Tris 4a. Facility Name (If not institution,		·)		4b. City,	Town, or	Location o		ovembe		2005 County of Deal		
			Rockville Nursi	ng Home			Rock						ntgomer	У	
	Funeral Director			1 □ M 2√2 F	ge (In yrs. la 	ast birthday) Yrs.	If Under Months	1 Year Days	Hours	Min.	8. Date of Bi (Month, D			thplace (State or Fountry)	
	ס		213-38-1172 Usual Residence of Decedent								anuary	79,19	930 St.	Thomas,V	
	farylar show	ŏ	10a. State 10b. County			, Town or Lo								10d. Inside City I	
	the N	Director	Maryland   Montgo: 10e. Street and Number	mery	Roc	kville	10f. Zip	Code				10g. Citi	zen of What Co		
	23e or		13205 Twinbrook	Pkwv #301			208	51				U.S.	Α.		
	tems	uner	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13. \		ent of Hi	spanic Orig n, Mexican	gin? (Sper i, Puerto F	cify Yes or Na Rican, etc.)		14. Race - Ame Black, Whit		
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/lan	Vental Mental Irked	To B	John Joseph Lul	oin Querard					Anr	ı Flo	restin	e Qu	ete1		
Maryland	2 sho and I is me raume		19a. Informant's Name/Relationsh										r Town, State, 2		
ē,	1 and Health Iem 27		Richard D. McNa 20a. Method of Disposition	lly/Guardia	20b. Pla	ace of Dispo	sition (Nam	e of			320, i		Jille N cation - City or	1D 20850 Town, State	
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mendal Hygiene. Importment of Health and Mendal Hygiene. Importment of Health and Mendal Hygiene. Importment of Health and Mendal Hygiene. Importment of the Traumatic event. The Medical Examinat must be notified at once.		21. Signature of Fulleral Service L	icensee Mary									Funera MD 208		
			23a. Part1. Enter the disease, or shock, or heart failure. List of	complications that cause	d the death.								11D 20C	Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	- Mut	Fipl.	e V	NYE	lom	d					Onset and Dea	ath
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):	1		ear						
		Jer	Sequentially list conditions, any leading to immediate cause. Enter Underlying	b. Due to (or a	s a pansagn	ence of):								-	
	ocuted nd transit	Examiner	that initiated events	c											
,160,	te be executed ysician and ie burial-transit	cal Ex	resulting in death) Last	Due to (or as	s a consequ	ence of):									
89				d								-			
Box	th certi ending r use a	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Ectopic pre	anancy				2	23d. Date of del	,	
P.O. E	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rat director, page 2 should be detached for use as the burial-transit	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown	4□Pregnant a 9□Unknown	at time of de		Other (spe						Month	Day Yea	ît
	that the	y Ph	Part II. Other significant condition	ns contributing to death	but not resu	lting in the u	nderlying ca	use give	n in Part I.		23e. Did	tobacco u	se contribute to	the cause of deat	th?
Vital Records,	w requires been sign should be										1 🗆	Yes 2	No 3□Pr	obably 4 Unk	inown
ecc	ne law re has be ge 2 sho	Completed									24a. Was	psy.	prior to	topsy findings ava	ailable se of
<u></u>	nysician: The la nis certificate has I director, page 2										1 Yes	2 ANo	death? 1 ☐ Yes	21XN0	
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Σ	al or Attend after death Director: / d in by the f	Certification;	4  Homicide determine	28e. Place of Ir building, e	itc. (Specify,	ne, rami, str	eet, ractory,	опісе			City or To			ural Route Number	<b>`</b>
	Hospita 4 hours Funeral	edical C	29a. Certifier (Check only one)	p Physician: To the bes examiner: On the basis and manner s	of examinati	vledge, death ion and/or inv	n occurred a vestigation,	it the tim	e, date and pinion, deal	d place, a th occurre	nd due to the d at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier		111	6	29c.	License	number	×10		29d. Dat	e signed (Monti	h, Day, Year)	
)	1.		> Patricia	10ms Ro	The	ag, Th	00	L	1519	1/6		No	V, 8,	2005	
>	Y		31 Name and address of person v	tho completed cause of	death Item	Т3а) (Ту, ө,	Print) 1/0	Di	ko 1	2-11	O, R	ock	willo	MD 208	241
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	trar's Signat	ure	AL A	11/	1	10	1	7	VIII	IIIV XUC	100
	Registr	ar	NOV 182	1005 January	, 15.	1	San								

			1 - For State Registrar	State of Ma	arylan		artmen tificat			and M	Re	g. No. U U	15	39393
	Physici /Medio		Decedent's Name (First, Middle, Last)	LOUISE		c. A	206	ER-	5		2. Date of Deat Month	Day	Year	3. Time of Death 9:45A M
	Examin		4a. Fecility Name (If not institution, give s FOREST GLEN	NURSING			51	LVEA	Location o	RIN			NTG	OMERY
	Funeral Director		102 22 1700		9 (In yrs. 9 2	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth June 16	, Year 1913	9. Birthp Cour Alt	place (State or Foreign ntry) una, PA
	e Maryland 3e-f ehow	ctor	Usual Residence of Decedent	ry		y, Town or Lo		-					1	0d. Inside City Limits ₩☐ Yes 2 ☐ No
	h with th	al Dire	10e. Street and Number 2700 Barker Stree	t			10f. Zip	Code 0910				og. Citizen of V United		ŕ
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "natural," or items 23a or 28e-f show any injury or other treumatic event. The Medical Evaluation into the notified of Ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2504 If Yes, Give Year or Dates:			Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	Blac	e Americk, White,	
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yland	ould be file Mental Hy arked oth atic event	To Be (	17. Father's Name (First, Middle, Last) unobtainable								(First, Middle, Mable	Maiden Surnam	10)	
Mar	alth and 2 sho		19a. Informant's Name/Relationship ( $Ty$ ) Donald Patton ( gra				-				<i>IRoute Number,</i> er Sprin			Code)
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	Physician /Medical Examiner		23a. Part1. Ent of the disease, or complishock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)	e cause on each in	vEU	MONI		e of dying	g, such as (	cardiac o	r respiratory arre	est,		Approximate Interval Between Onset and Death 3 days.
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		Completed	3. Osteoporo 5. depression		05+	eoart	インディ	45			24a. Was ar autopsy perform 1 \( \text{Yes} \) 2	yad?	rior to cor leath?	psy findings available mpletion of cause of 2 No
Division of Vital Records,	To the Hospital or Attending Physicien: The Ismiting 24 buours either death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page 2	To Be	27. Manner of Death	ospital: 1 ☐ Inpatie 28a. Date of Injui (Month, Day		ER/Outpatien		A Othe	r: 4 X Nur	rsing Hon	(Check only one	nce 6 □Othe		y)
IVISION	l or Attendin efter death. Director: Aft in by the fun	Certification;	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At ho	Injury ome, farm, stre	М	1 🗀 Y	? ′es 2 □ N		28f. Location (Str City or Town,		er or Rura	l Route Number,
_	To the Hospitel or Attendi within 24 hours efter death. To the Funerel Director: A completely filled in by the fo	edicai Ce	29a. Certifier 1 Certifying Phys	sician: To the best of the control of the basis of and manner sta	examina	wledge, death tion and/or inv	occurred restigation,	at the tim in my op	e, date and inion, deat	place, a	and due to the ca	use(s) and mar te and place, a	nner as st	ated. the cause(s)
	To the within 2 To the Complet	Mec	29b. Signature and title of certifier					. License				d. Date signed		
			Chowdley, n			- 00-1		D 431				11.17.		
1	(6)		30. Name and address of person who co	mpleted cause of d	eath (Item	1 23a) (Type.	rgia	Ave	; 5.	ilve	r Spriz	g, M	22	0902
2	Sta Registr	_	31. Date filed (Month, Day, Year) NOV 2 2 2005	Serve.	aris Signa	lure de	B							

			1 - State Registra MEND#31s30#3	State of 211/18/05	of Marylai	nd / Depa	artment <i>rtificate</i>	of H	ealth a Death	and M		giene		393	194
			Decedent's Name (First, Middle, L.	ast)	12.7.200						2. Date of De	aath		3. Time o	of Death
	Physici		SOPHIE ROSENBAUM								Month NOVEMBER	Day		1:15	ър М
1	/Medio Examin		4a. Facility Name (If not institution, g		4b. City, T	own, or	Location (				County of De				
	LAGITIII		SUBURBAN HOSPITAL				BETHE	ΔŒ				M	ONTGOMER	v	
	Funeral			Sex	7. Age (In yrs	last birthday)	If Under 1	Year	If Under		8. Date of Bir	rth	9. B	irthplace (State	or Foreign
	Director		105-32-0752	1 ☐ M 2 🖾 F	99	Yrs.	Months	Days	Hours	Min.	(Month, Da JANUARY			Country)	
	D		Usual Residence of Decedent										00 1100		
	ylan		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside C	City Limits
	Ma -1-	Director	MD MONTGOME	RY	СН	EVY CHAS	E							1X Yes	s 2 □ No
	n the	re	10e. Street and Number				10f. Zip C	ode				10g. Citi	zen of What (	Country?	
	73 wil	<u>a</u>	3714 WOODBINE STREET				2081	5				UNITE	D STATES	OF AMERI	CA
	dea	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decede	nt of His	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)		14. Race - An	erican Indian,	
9	after or Ite		1 Never Married 2 Married	1 Tes	2 📝 No				Specify:		nican, etc.)		Black, Wr		
සු	rai'.	ρ	3 ⊠ Widowed 4 □ Divorced	Year or D			1 □ Yes 2	AJ NO	эреспу:				Specify: WH	TTE	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then 'natural', or liems 23a or 28e-f ehow ont, the Modical Examiner must be notified at	Completed	15. Decedent's (Specify only highest of	Education rade completed)			dent's Usual kind of work			t of worki	ina	16b. Ki	nd of Busines	s/Industry	
7	thin	ם	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use	retired)			9				
2	or th	ပ္ပ		5+		TEACH	ER					]1	EDUCATIO	N	
Maryland	al Hy	Be	17. Father's Name (First, Middle, Las	it)					18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
<u>a</u>	Ment Ment arke	2	JACOB ROFSKY						VERA	UMANS	KY				
<u>a</u>	and and is m		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (	Street a	nd Numbe	er or Rura	i Route Numb	er, City o	r Town, State,	Zip Code)	
	end palith n 27		IRA ROSENBAUM, SON			3714	WOODBIN	E STI	REET,	CHEVY	CHASE,	MD 20	815		
Baltimore,	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  The Marylant: If Item 27 is marked other than "natural; or liems 23a or 28e-1 show any injury or other traumatic event, the Marylan Examinar manter nature and the notified at once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3	□ Bomoval from		Place of Dispo cemetery, crer	sition (Name	of er place	) !		ate	20c. Lo	cation - City o	r Town, State	
Ĕ	Page nent ment in the ment in		4 □Donation 5 □ Other (Spec		State	EAN MEMO			!	1-13-	2005	OLNI	EY, MD		
<u>≡</u>	mit. partn ports y inju		21. Signature of Funeral Service Lic	ensee		22	. Name and	Address	s of Facilit	HINE	S-RINALD			E. INC.	
œ	89229		along	Donn	000						UE SILVE				
			23a. Part1. Enter the disease, or co shock, or heart failure. List yn	mplications that	caused the dea	th. Do not ent	er the mode	of dying	, such as	cardiac c	r respiratory a	rrest,		Approxima Interval Be	te
	Physician		Immediate Cause (Final											Onset and	
1	/Medical		disease or condition resulting in death)	a. PNEUN	ON LA (or as a conse	cuence of):								<u> </u>	
	Examiner				RATORY F										
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b	(or as a conso					-					
	uted ansit	듣	cause. Enter Underlying Cause (Disease or injury that initiated events												
~	exec n and al-tra	Examin	resulting in death) Last	c. Due to	(or as a conse	quence of):									
8760,	cate be executed physician and the burial-transit	dlcall													
289	ficate p phy is the	pa pa													
×	The law requires that the death certificate has been signed by the ettending lage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregn								23d. Date of de	alivery	
Box	ette ette	clai	in the past 12 months?		oirth 2 Feta nant at time of		Ectopic preg Other (spec						Month		Year
P.O.	y the	ıysı	1 □ Yes 2 ₺ No 9 □ Unknown	9□ Unkn			, , , , , ,	,,							
	that ed b deta	4	Part II. Other significant conditions	contributing to d	eath but not re	sulting in the u	nderlying cau	ise give	n in Part I.		23e. Did t	tobacco u	se contribute	to the cause of	death?
g	sign d be	d by									10	Yes 2	∐No 3⊟F	robably 4 🗀	Unknown
Records,	w requir been si should	Completed									-			-	17.5
ဆို	9 law	μ									24a. Was		24b. Were a prior to death?	utopsy findings completion of o	available cause of
=	, u -	S		-							1 Yes			s 2□No	
Division of Vital	Attending Physician: Thir death. •ctor: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital				T 011 -		of Death	Check only	олеј			
5	Physical this call dir	္	1 Yes 2 No	Hospital: 1		ER/Outpatien		1	4 🗀 Nu		ne 5 🗆 Resi			ecify)	
2	ding F	ü	27. Manner of €eath  1 Natural 5 Pending		of Injury th, Day Year)	28b. Time of Injury		Work			28d. Describe	how injur	y occurred		
. <u>S</u>	tend leath tor: / the f	Certification:	2 Accident investigati 3 Suicide 6 Could not	he -			М		es 2 🔲						
₹	or Attendated after death	Ħ	4 Homicide determine	d Zoe. Place	of Injury - At h ing, etc. <i>(Speci</i>		eet, factory,	office		1	28f. Location ( City or To			Rural Route Nun	nber,
	To the Hospital or Attending Physician: whim 24 hours after death as the this certific To the Funeral Director: After this certific completely filled in by the funeral director.	ပီ													
	Hospita 24 hours Funeral tely filled	edical	29a. Certifier 1 \(\sum \) Cartifying F (Check only 2 \sum Madical Ext	hysician: To the biminer: On the b	best of my kn asis of examina	owledge, death ation and/or inv	occurred at	the time	e, date an inion, dea	d place, a	and due to the ed at the time.	cause(s) date and	and manner a	s stated. e to the cause(s	s)
	To the Hospital within 24 hours a To the Funeral a completely filled	Med	one)	and man	ner stated.										
	To To		29b. Signature and title of certifier				290.	License	number	17		1.1	1.	th, Day, Year)	
,	7/-		///				16	1	57	+		111	16/0		
K	(5)		30. Name a dad ress of person wh	completed cau	se of death (Ite	m 23a) (Type,	Print)					- 1			
	(U)		MARJORIE F. DANNIS,				DAD, BE	THESI							
3	Sta Registr		31. Date filed (Month, Day, Year)		Registrar's Sign		E.		K	S. S. S.	and I				
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DHMH 17 Rev 1/2001

ROSEN BAUM, SOPHIE Illiolos

			1 - For State Registrar	State of M	aryland /		artment <i>tificate</i>			and Me	-	giene	005	3939	95
	Physici	an	Decedent's Name (First, Middle, Last)     CT OD TA		TIADDCO	NT.					2. Date of De Month	Day	Year	3. Time of	
	/Media	ĉal	GLORIA  4a. Facility Name (If not institution, give		CHARDSO	IN	4b. City, To	own. or	t ocation o	of Death	OCT	28	2005 County of Deatl	6:52	РМ
	Examir	ier	NATIONAL NAVAL MEI				BETH			, Doda,			NTGOMER		
	Funeral		5. Social Security Number 6. Se	7. Ag	e (In yrs. last		If Under 1 Months	Year Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th v, Year)	9. Birth	place (State or	r Foreign
	Director		231-78-0527 Usual Residence of Decedent	J W 2 4	52	Yrs.					02/12/	1953	Virg		
	aryland show		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside Cit	y Limits
	80-f sl	ctor	Virginia Stafford		Staffo	ord								1∭ Yes	2 🗆 No
	with th	Dire	10e. Street and Number				10f. Zip C					•	en of What Co	intry?	
	ns 23	Funeral Director	28 Cookson Drive	12. Was Decedent	Ever in U.S.	13. \		556	spanic Orio	nin? (Spec	cify Yes or No	USA	4. Race - Ame	ican Indian	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Medical Express.	þ	1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed Forces?  1 X Yes 2 If Yes, Give Year or Dates.	No	i	fYes, specif		Specify:	, Puerto F	cify Yes or No Rican, etc.)		Black, White Specify:		
2-0	72 ho	Completed	15. Decedent's Edu (Specify only highest grad	cation		a. Deced	lent's Usual kind of work	Occupa done di	tion	of workin	ıa.	16b. Kir	nd of Business/I		
121	within no.	mpi	Elementary/Secondary (0-12)	College (1-4or		`life. L	OO NOT use	retired)			3	W.D	1 1		
d 2	filed withi Hygiene. other then		12 17. Father's Name (First, Middle, Last)		E	SSIS	tant l			r's Name	(First, Middle,		onalds Sumame)		
<u>Ian</u>	should be ind Mental I marked o	To Be	Marvin Linwood Si	lls					Lizz	ie Ma	e Harr	ison			
Maryland 21215-0036	2 should be filed v and Mental Hygie is marked other t reumetic event, III		19a. Informant's Name/Relationship (Ty			9b. Mailin	g Address (	Street a	n <i>d Numbe</i>	r or Rural	Route Number	er, City or	Town, State, Z	ip Code)	
வி	Health Health tem 27 other tre		Charles Richardson 20a. Method of Disposition	1/ Husban			okson sition <i>(Name</i>		ve S		ord, VA		56 cation - City or 1	own State	
Baltimore,	0 0		1  Burial 2  □ Cremation 3  □ F  '4  □ Donation 5  □ Other (Specify)	lemoval from State	Qua	tery, cren In LiC	o Nat	r place Lona	11				n le, V		
altii	permit. Pag Department Importent: I eny injury o		21. Signature of Funeral Service Licens	90			etery Name and	Address	s of Facility	y Robe	ert E.	Evan	s Funer	al Home	
<u> </u>	88 5 8		KelfAT			16	000 A1	nap	olis	Road	l Bowie	, MD	20715		
	Pnysician /Medical Examiner		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each li a. SUBARACI	ne.	IEMOR		of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Betw Onset and D	veen
	cuted nd nd ransit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a cons <b>equen</b> d	:e of):									
8760,	ate be executed hysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as	a consequenc	e of):									
Box 6	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal dea		Ectopic preg					2	3d. Date of deliv Month	,	ear
rds, P	signed d be de	by	Part II. Other significant conditions con	ntributing to death b	ut not resulting	in the ur	iderlying cau	se giver	n in Part I.			obacco us Yes 2	e contribute to No 3 ☐ Pro	the cause of de bably 4 🗍 Ur	
H.	The ate h page	Completed								-			24b. Were aut prior to co death? 1 \( \sum \text{Yes} \)	opsy findings a ompletion of ca	vailable use of
Vita	Phyeicien: this certific ral director,	Be	25. Was case referred to medical examiner?	lospital:				Other	~		(Check only o				
of		n: To	1 ☐ Yes 2X No 27. Manner of Death	28a. Date of Inju	ry 28b	. Time of	3 □ DOA 280	. Injury Work	4 LI NUI	-	e 5 🗌 Resid 8d. Describe l		Other (Specioccurred	fy)	
ion	Attending I death. ctor: After y the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	М		? es 2□N	No					
Division	ire ire n b	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inj building, et	ury · At home, c. <i>(Specify)</i>	farm, stre	eet, factory, o	ffice		28	Bf. Location (S City or Tov	Street and vn, State)	Number or Rui	al Route Numb	er,
	To the Hospitel (within 24 hours at To the Funerel D completely filled in	ledicai	29a. Certifier 1 X Certifying Physical Check only 2 Medical Examinates	sician: To the best ner: On the basis of and manner sta	f examination a	ge, death and/or inv	estigation, in	my opi	nion, deat	d place, ar h occurred	d at the time,	date and p	place, and due	o the cause(s)	
)	To the within 2 To the complet	¥	29b. Signature and title of certifier	1-	( D.		01	0600	number 054A	(IN)	j	Vov	signed (Month,	Day, Year)	5
			30. Name and address of person who commario J. CARDOSO	mpleted cause of d	eath (Item 23a USNR	ı) (Type, I	, -				L MEDIO 0889-50		ENTER		
:	Sta		31. Date filed (Month, Day, Year)	32. Refistr	ar's Signature	L.	R as								
40	Registr	ar	MOV 0 3 2	003	m d	1	A STATE	9							

			For State Registrar	State of Marylan		artment of H <i>tificate of L</i>			ie <b>že</b> () () 5 <sub>eg. No.</sub>	39396			
	Dhusisi		Decedent's Name (First, Middle, Last)					2. Date of Deat Month	Day Ye	3. Time of Death			
	Physici /Medic		Peggy-Gra	ace Rubb				Novemb	er 28, 20	005 9:45 A M			
	Examin		4a. Facility Name (If not institution, give stre	Location of Death		4c. County of E							
			Millennium at South			Edgewa				Arundel 			
п	Funeral		5. Social Security Number 6. Sex 1 □ N	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Foreign Country)			
Н	Director		047-24-3371 Usual Residence of Decedent	74	113.			9-27-19	31 C	onnecticut			
	show		10a. State 10b. County	10c. Cit	y, Town or Lo	cation		-		10d. Inside City Limits			
	Mary -1 sh	ţo	Maryland Anne Arun	Total	ewater					1 ☐ Yes 2X No			
	the the roll	rec	10e. Street and Number	der ing	CWALCE	10f. Zip Code		1	0g. Citizen of Wha	t Country?			
	h with	i D	1 Pennsylvania Ave			2103	37		USA				
	deat mms 2	ner		Was Decedent Ever in U. Armed Forces?	.S. 13. \	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp.	ecify Yes or No-		American Indian,			
21215-0036	72 hours after death with the Maryland "netural", or Itams 23a oc 28a-1 show cleal Examiner must be notified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		Tes, specify Cuba	Specify:	ricali, etc.)		<sup>vhite, etc.</sup> White			
9-0	72 ho	ted	15. Decedent's Educat (Specify only highest grade of		16a. Deced	lent's Usual Occupa	ation	ina	16b. Kind of Busin	ess/Industry			
21	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	)	,,,,					
	ed wi	Con		years	Ow	ner/Oper			Ballet	School			
pu	be fit d oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name						
yla	ould Men parka	P_	Launcelot John					argaret					
Maryland	s 1 and 2 should be filed within 72 hc f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, it is Midical		19a. Informant's Name/Relationship (Type		1	g Address (Street a				te, Zip Code)			
	1 and 2 Health Iem 27 othar tra		Bonnie L. Beigel/ Do			idge Ave.		The state of the s	21037 20c. Location - City	or Town State			
٥	Pages nent of I nnt: If its ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem			sition (Name of natory or other place							
Baltimore,			4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 12-1-05 Crownsvill 21. Signature of Eneral Service Lipensee 22. Name and Address of Facility George P. Kalas Funer										
Ba	permit. Departr Importe any inje		> Mort Villac	dgewater	MD 21037								
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
	Physician		Immediate Cause (Final disease or condition	(alde	ac A	milleur	an			Onset and Death			
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):								
	LAMIIIICI	_	Sequentially list conditions, b	Due to (or as a conseq									
	ed ssit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	dence or):								
	and al-trar	xan	that initiated events c. resulting in death) Last	Due to (or as a conseq	uence of):								
68760,	ificate be executed g physician and as the burial-transit	edical Examiner											
687		edic	u										
Вох	eath certif attending for use a	D/M	IF FEMALE: 23c. Was decedent pregnant 23c	If yes, outcome of pregna		<b>1</b>			23d. Date of	delivery			
	law requires that the death cert as been signed by the attendin 2 should be detached for use a	Physician/M	in the past 12 months? 1 □ Yes 2 ☒No	1 Live birth 2 Feta 4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year			
P.0	at the d by the tached	hys	9 □ Unknown	9□ Unknown									
	rw requires that s been signed b should be det	by P	Part II. Other significent conditions contri	buting to death but not res	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribu	e to the cause of death?			
ord	aquira en si ould I	ted	Jetuca a	11				1 □ Ye	es 2□No 3□	Probably 4 Unknown			
of Vital Records,	has be	Completed	- Rullie t	5 thrue				24a. Was a autops		autopsy findings available to completion of cause of			
I R	ate pag	Con						perform 1 ☐ Yes 2	ned? deat 2 No 1 □				
/ita	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deatl	n (Check only on	е)				
)	shysis this c	P	1 ☐ Yes 2 No		ER/Outpatien		4 Nursing Ho		nce 6 Other (	Specify)			
	Jing P	ion:	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe ho	w injury occurred				
isi	death. ctor: A y the fu	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm etc		Yes 2 □No	281 Location (St	reet and Number o	r Rural Route Number,			
Division	of or Attancater death Diractor:	Certification:	4 Homicide determined	building, etc. (Specif	y)	set, factory, office		City or Town	, State)	Agrai Addie Number,			
_	spital cours neral filled	ai C	29a. Certifier Certifying Physic	ian: To the best of my kno	wledge, death	occurred at the tim	e, date and place.	and due to the ca	ause(s) and manne	r as stated.			
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medicel Exemine one)	r: On the basis of examina and manner stated.	tion and/or in	estigation, in my op	pinion, death occurr	ed at the time, da	ate and place, and	due to the cause(s)			
	To the To the Comp	Me	29b. Signature and title of certifier			29c. License	number	2:	9d. Date signed (M	onth, Day, Year)			
						05	1028		11.28.	05			
	10		30. Name and address of person who com	pleted cause of death (Item	23a) (Type,	Print)	n: 1		1 1 2	~ A- 1			
	10		Aditya Unopra M	D, 600 KIO	agely	AVC. #2	31 Anno	polis,	MD 214	701			
	Sta		31. Date filed (Month, Day, Year) DEC 0 6 2005	32 Registrar's Signa	iba(e	and I		1					
	Registi	al	DEO 0 0 2003	fred the State of	1	TI Section							

				For State	S	tate of Ma	aryland			Health and I	Mental Hy	ygier	enns	39397
			/8	- Registrar	14: 4.90			Cei	tificate of	Death	100	Reg. 7	10.000	0 3 0 3 .
	P	hysici	an	1. Decedent's Name (First, Interry Jera)		L					2. Date of D Month	0	ay Year	3. Time of Death
4		/Medic		4a. Facility Name (If not insti					4b. City. Town.	or Location of Death	NOVEMB	- T	15,2005 lc. County of Dea	1:17 P M
2	100	-xaiiiii	EI	CIVISTA MED	•				LAPLA				CHARLES	
3	Fu	ineral		5. Social Security Number	6. Sex	7. Age	e (In yrs. lasi	birthday)	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of B	irth	9. Bir	thplace (State or Foreign
٧)	Dir	ector		236-66-902.		2   F	61	Yrs.	Wortens Days	riouis wiii.	Aug.	1,	1944	WVA
	and	A		Usual Residence of Deceder 10a. State 10b. Co			10c. City, T	own or Lo	cation					10d. Inside City Limits
S	Maryi	f e how	Po	MD Cha	arles		Iss							1 ☐ Yes 2∰Kio
0	the	28a	rec	10e. Street and Number	arres		TSS	ue	10f. Zip Code			10g. (	Citizen of What Co	ountry?
HMON	h with	23a or 28a-f ehovet be notified at	al D	14455 Jasm:	ine Cr	t.			2	0645			USA	
I	r deal		Funeral Director	11. Marital Status	12.	Was Decedent B Armed Forces?	Ever in U.S.	13. \	Vas Decedent of	Hispanic Origin? (Span, Mexican, Puert	pecify Yes or N	0-	14. Race - Ame Black, Whit	
J	36 s afte	and a	by Fu	1 Never Married 2	Marned 1	Yes 2 XN	lo		☐ Yes 2X No					hite
3	<b>5-0036</b> 72 hours after death with the Maryiand	naturaf, or fleme dical Examinar m		3 Widowed 4 Divo	edent's Education	Year or Dates:		6a Dacac	lent's Usual Occu	Ination		165		
76	15. in 72		Completed	(Specify only h	nighest grade col	mpleted)		(Give	kind of work done	during most of wor. ad)	king	160.	Kind of Business	industry
			E O	Elementary/Secondary (0- 12	12)	College (1-4or 5	+)	Ste	am Fitt	er			Union	
7	land 2 id be filed ental Hygin	d othervent,	Bec	17. Father's Name (First, Mic						18. Mother's Nam		e, Maide		
	laryland 2 2 should be filed and Mental Hygi		Lo	Terry Jesse	Richm	ond				Evelyn		-	hmond	
~	Maryl	e 2		19a. Informant's Name/Rela		•	12	19b. Mailin	g Address (Stree	ne Ct.	ral Route Numb	ber, City		Zip Code)
S.	e, M	item 27 other t		Deborah Ric	hmond/	Wife			sition (Name of	ne ct.	Date		20645 Location - City or	Town Chair
ERRY	O 8 5	= = =		1X Burial 2 ☐ Crema		val from State	cem	etery, cren	natory or other pla				,	ŕ
F	Baltim permit Pag Depertment	important: eny injury o once.		4 □Donation 5 □ Oth  21. Signature of Funeral Ser		4	M0094							f,Maryland
1	Balt permit. Depertr	eny ir		1 Land	C. E.	int)			AREHART P.O. BO	SECHOLS X 567,L	FUNER A PLAT	AL 'A M	HOME,P	.A.
	ng ng	微力		<ol> <li>Part1. Enter the disease shock, or heart failure.</li> </ol>	se, or complication List only one ca	ons that caused ause on each lin	the death. (	Do not ente	er the mode of dy	ing, such as cardiac	or respiratory a	arrest,		Approximate Interval Between
4		ician		Immediate Cause (Final disease or condition resulting in death)	a	are	hos	3è	> 6	bel				Onset and Death
		dical niner		iesulting in dealing		Due to (or as a	a consequen	ce of):						
		· in	e	Sequentially list conditions, if any, leading to immediate	b	Due to (or as a	a consequen	ce of):						
	nted	ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>.</b>									
	38760, icate be executed	physician and the burial-transit	Exa	resulting in death) Last	U	Due to (or as a	consequen	ce of):						
	<b>68760,</b> ficate be ex	physici s the bu	edicai		d									
				IF FEMALE:							<u></u>			
	Box sath cert	attending for use as	ian/	23b. Was decedent pregnan in the past 12 months?		fyes, outcome of □Live birth	2 Fetal de	ath 3	Ectopic pregnanc	;y			23d. Date of del Month	ivery Day Year
	P.O.	ched	by Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		I□Pregnant at 9□Unknown	time of death	1 5∟	Other (specify) _					,
	G ta	detac	y Ph	Part If. Other significant cor	nditions contribu	iting to death bu	it not resultin	g in the ur	derlying cause gr	ven in Part I.	23e. Did	tobacco	use contribute to	the cause of death?
	Division of Vital Records, for Attending Physicien: The law requires taller death.	been signed by the should be detached									1 🗆	Yes :	2 □ No 3 □ Pr	obably 4 Onknown
	0 ×	2 short	Completed								24a. Was		24b. Were au	topsy findings available
	R ef	2 0	E o								auto perfe	opsy ormed? 2 N	death?	completion of cause of
	ien:	0	Bec	25. Was case referred to me examiner?	dical					26. Place of Dea			0 12,03	202.110
	of V	d d	္	1 ☐ Yes 2 ☑ No	Hospi	1 🗷 inpatier		Outpatien:	00 0011		ome 5 Res	idence	6 □Other (Spec	cify)
	on C	In er	inol.			Ba. Date of Injur (Month, Day	Year) 28	b. Time of Injury	28c. Inju Wo	ry at	28d. Describe	how inj	ury occurred	
	isic Isic	y the funer	licat	3 ☐ Suicide 6 ☐ Co	vestigation ould not be	Re Place of Inju	rv - At home	farm stre	M 1	]Yes 2□No	28f Location /	(Street a	and Number or Ri	rai Route Number.
	Div afor A	d in b	Certification:	4 ☐ Homicide de	etermined 2	building, etc	. (Specify)	, 121111, 3416	et, factory, office		City or To	wn, Sta	te)	rai rioute Number,
	Division of Vital Records, P.O. Box ( To the Hospitel or Attending Physicien: The law requires that the death certif within 24 hours after death.	completely filled in by		29a. Certifier 1 Cer (Check only 2 Med	tifying Physicia	n: To the best of	of my knowled	dge, death	occurred at the ti	me, date and place, opinion, death occur	and due to the	cause(	s) and manner as	stated.
	To the H within 24	nplete	Medical	Une,		and manner sta	ted.	2110201 1110			red at the time,			
	To	Ö	-	29b. Signature and title of ce	iester	1.5)			29c. Licen:			290. D	ate signed (Monti	, Day, Tear)
			-	13		atod anyon of de	ath (Ita- 00	a) (T '		056949		·	1/12/0	4
	RS	<		30. Name and address of pe KAMAKSHI BAI		620 CRA		,		T A DT A TP A 3 AT	D 20646			
		Sta	te	31. Date filed (Month, Day, )		32. Relistra	r's Signature	<u> </u>	Li 102	LAPLATA,M	v.ZU04b			
	The second second	legistr	ar	NUV	T Q \( \text{COD} \)	Alexa	us h	19	me					

			1 - For Stete Registrer	State of M	aryland / Dep <i>Ce</i>	artment of F			iene 005	39398
	Physici /Medic		1. Decedent's Name (First, Middle, Las Marcella	")	S	loan		2. Date of Deat Month	th Day Year 2005	3. Time of Death 4 11 1 5 PMM
	Examir Funeral		4a. Facility Name (If not institution, give 15801 Lower G	eorges (	creek Rd ge (In yrs. last birthday	4b. City, Town, or	Location of Death		4c. County of Dea Allegar	1y thplace (State or Foreign
	Director Mot		215-16-4015  Usual Residence of Decedent  10a. State  10b. County	JM 2016	82 Yrs.		1000	March 11,		Maryland  10d. Inside City Limits
	th the Mar or 28a-fal	Director	Maryland Alleg	any		10f. Zip Code	onaconing	10	0g. Citizen of What Co	1 XYes 2 □ No ountry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, Ira Medical Franciant must be indified at once.		1580 Lower Ge  11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	orges Creek I  12. Was Decedent Armed Forces? 1	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	21539 ispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	U.S.  14. Race - Ame Black, Whit	erican Indian,
21215-0036	d within 72 hou giene. ir than "natura Ine Medical E	Completed by Funeral	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ıcation	(Give	dent's Usual Occup kind of work done of DO NOT use retired HOI	durina most of wor	king	16b. Kind of Business/	Industry
Maryland 2	iould be filed Mental Hyg tarked othe	To Be C		George Allen					ie Gardner	
e, Mar	1 and 2 sh Health and Health and Hear traum		19a. Informant's Name/Relationship (T) Charles F. Slo 20a. Method of Disposition	•	19b. Maili	2 Dudl		onaconing, N	City or Town, State, 2 Maryland, 2153	9
Baltimore,	t. Pages rtment of th rtant: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐ in the control of the		Cumber	matory or other plac rland Cremato	ory	November 22, 2005	Cumberland	, Maryland
g	permi Depar Impor any ir		21. Signature of Funeral Service Licens  L. Marker  23a. Part / Enter the disease, or comp	2			Lonaco	ning, Maryla	P.A., 8 East M and, 21539	ain Street,
	ficate be executed / Medical Example / Medical street the private transit street from the private from the p	dicai Examiner	shook, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	ASCVB as Due to (or as	tive hear a consequence of):	t failu	re			Interval Between Onset and Death Yrs
r.O. box o	death certi e attending id for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	⊒Ectopic pregnancy □ Other (specify)			23d. Date of deli Month	very Day Year
	The law requires that the ate has been signed by thoage 2 should be detached.		Part II Other significant conditions co	ntributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.		acco use contribute to s 2□No Pro	
al necc		Completed						_ '	prior to death? No 1 Yes	topsy findings available completion of cause of
Division of Vital Records,	ding Phys	Certification; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be	lospital: 1 □ Inpatie 28a. Date of Inju (Month, Da	ry 28b. Time o Injury	f 28c. Injury Work M 1 🗆 Y	er: 4 ☐ Nursing He	28d. excribe how	nce 6 Other (Spec	
2			4 Homicide determined  29a. Certifier 1 Certifying Phy	building, etc	of my knowledge, deat	n occurred at the tim	e, date and place	City or Town,	use(s) and manner as	stated
	To the Hospital or within 24 hours afte To the Funeral Discompletely filled in	Medical	29b. Signature and title of certifier	and manner sta	ned.	vestigation, in my op	oinion, death occur 	red at the time, da	d. Date signed (Month NOV 22 20 nd MD 215	to the cause(s)
	Sta Registr		30. Name and address of person who copy and Snow, M.D.  31. Date filed (Month, Day, Year)	, Deputy	eath (Item 23a) (Type,	Print)				

			1 - For State Registrar	State o	f Maryland / De <i>C</i>	partment of ertificate			iene og. No. 005	39399
			1. Decedent's Name (First, Middle,	Last)				2. Date of Dea Month		3. Time of Death
	Physici /Medio		CARL GORDON S	WEITZER				Novembe	r 21 2005	12:34 A M
	Examir		4a. Facility Name (If not institution, g	give street and nur	mber)	4b. City, Tox	vn, or Location of De		4c. County of Dea	
		e <sup>to</sup>	3767 Swanton Roa	ıd		Swante	on		Garrett	
5	Funeral		,		7. Age (In yrs. last birthd	Months D		Irs. 8. Date of Birth in. (Month, Day	Year) 9. Bir	thplace (State or Foreign
	Director		215 42 4404	1 X M 2 □ F	94 Yrs			Mar 9		
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	Manyl f eho	ō	MD Garret	t	Swanto					1X Yes 2 □ No
	n the Maryland r 28a-f ehow incliffed at	Director	10e. Street and Number			10f. Zip Co	de	1	0g. Citizen of What Co	ountry?
	with Be or	급	3767 Swanton 1	o a		215		'	USA	ountry ?
	ours after death with the Maryland ral', or Items 23e or 28a-f ehow Examinat must be notified at	Funeral	11. Marital Status	<del></del>	edent Ever in U.S. 1			(Specify Yes or No-	14. Race - Ame	ancan Indian
"		Fu	1 ☐ Never Married 2 ☑ Married	Armed Fo	rces?	If Yes, specify	Cuban, Mexican, Pu	erto Rican, etc.)	Black, Whi	
93	hours after tural', or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv Year or D	re	1 ☐ Yes 2 🖾	No Specify:		Specify: W	hite
21215-0036	2 hg	Completed	15. Decedent's		16a. De	cedent's Usual O	ccupation		16b. Kind of Business	/Industry
218	within 7 ene. than "r	ple	(Specify only highest Elementary/Secondary (0-12)	College (1	life	DO NOT use r	one during most of t etired)	vorking	D (111	
2	od will	Son	7	3.		carpente	er		Building	
P	be filed tal Hygi d other event, I	Be (	17. Father's Name (First, Middle, La	st)			18. Mother's N	lame (First, Middle, I	Maiden Sumame)	
<u>a</u>	Menta Menta arked	To	John C. Sweitze	r			Homa H	Bowser		
Maryland	S E E		19a. Informant's Name/Relationship						, City or Town, State, .	Zip Code)
Σ.	and salth n 27		Michael Sweitze	r	F	O Box 38	35 Oaklar	nd, Md. 21	550	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	DRomoval from 1	cometent (	sposition (Name or rematory or other	of rplace)	Date	20c. Location - City or	Town, State
Ĕ	Page nent int: fi		4 □ Donation 5 □ Other (Spe		State	,	ematory 1	1-23-05	Cumberland	, Md
a	permit. Departn Imports any inju		21. Signature of Figure Service Lig	ensee /		22. Name and A	ddress of Facility		rct FU	
œ	8 9 E E 9		/ Harrid K	1. D1	rdock	21 N. 2r	nd St. Oa	kland, MD	21550	
			23a. Part*. Enter the disease, or co shock, or heart failure. List or	mplications that c	aused the death. Do not	enter the mode of	dying, such as card	liac or respiratory arre	est,	Approximate Interval Between
	Physician	i	Immediate Cause (Final		E INMALA	7 al A	M THER	MAC IN	SARIE	Onset and Death
in the	/Medical		disease or condition resulting in death)	a	or as a consequence of):	W/ //	1700	ATAC INI	VILLES	
2	Examiner				, ,					
	# 1	Je.	Sequentiary list conditions, if any, leading to immediate	Due to (	or as a consequence of):					
	outed ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	C						
ó	en ar	EX	resulting in death) Last	Due to (	or as a consequence of):					
8760,	cate be executed physicien and the burial-transit	dicai		d						
9	certifica nding ph use as th	led	IE EEVALE.							
Вох	eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregnancy irth 2 Fetal death	3 □Ectopic pregn	ancy		23d. Date of dea	ivery
	death se atten	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of death	5 ☐ Other (specif			Month	Day Year
P.0	that the de led by the a detached t	Physician/Me	9 Unknown	9L Onkno	OWN					
	requires that sen signed b	by	Part II. Other significant conditions	contributing to de	eath but not resulting in the	underlying cause	e given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Records,	w requir been si should I	eq						1 □ Ye	s 2 No 3 Pr	obably 4 Munknown
ပ္ထ	2 0 5	piet						24a. Was ar		topsy findings available
æ	The lav	Completed						autops:	ned? death?	completion of cause of
		Ф	25. Was case referred to medical				26 Place of D	eath  Check only one		2 No
2	× 0 5	OB	examiner? 1∰Xes 2 □ No	Hospital:	npatient 2 ER/Outpat	ient 3 DOA	Oth		nce 6 <b>/ 2</b> ther (Spe	ch Scono
		n:T	27. Manner of Death		of Injury 28b. Time		Injury at Work?		w injury occurred	ow ocene
<u>.</u>	Attending I	atio	1 □Natural 5 □ Pending 2 ☐ Accident investigat		h, Day Year) Injur		Work/ 1 ☐ Yes 2 ⊠No	VICTIM	OF HOUSE	FIRE
	Atte or de by th	Certification:	3 Suicide 6 Could not	be 28e Place	of Injury - At home, farm, ng, etc. (Specify)	street, factory, of	lice	28f. Location (Sti	reet and Number or Ru	
ā	al Dir	le T	4 - Homoles		SIDENCE			3767 SWV		WANDON, MO
	papit hour uners ly fille		29a. Certifier 1☐ Certifying	Physician: To the	best of my knowledge, de	ath occurred at th	ne time, date and pla	ce, and due to the ca	use(s) and manner as	stated
	To the Hospital or Attend within 24 hours after dealt To the Funeral Director: completely filled in by the	edical	one)	arriner: On the ba and mann	isis of examination and/or	investigation, in r	ny opinion, death oc	curred at the time, da	ite and place, and due	to the cause(s)
	To t To tl comp	×	29b. Signature and title of certifier	`		29c. Lie	cense number	29	d. Date signed (Monti	h, Day, Year)
			• Unes	2			OCME	No	ovember 21,	2005
-	2		30. Name and address of person wh	o completed cause	e of death (Item 23a) (Typ	e, Print)		110		1000
1	2		ANA	RUB10,	MD	111	Penn Stre	et Baltim	ore, Maryl	and 21201
	Sta	te	31. Date filed (Month, Day, Year)	32. R	gristrar's Signature				,, -	
	Registr	ar .	NOV 2 3	2005	Marier &	Conde ?				

State of Maryland / Department of Health and Mental Hygienen - State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DONALD COOPER STEWART, JR. Nov 25 2005 2:15 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot Genesis HealthCare -The Pines Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year)

OCT 2 1952 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1(XM 2□ F 214-60-8001 53 MARYLAND Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at 1 X Yes 2 No Directo TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23 A CRABAPPLE CT 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: WHITE Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 COMMERCIAL BUILDING BRICKLAYER filed is marked other t of Health and Mental Hv 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DONALD C. STEWART ANN COLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANN C. BOWDLE/MOTHER 23A CRABAPPLE CT., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter 1X Burial 2 Cremation 3 Removal from State SPRING HILL CEMETERY | 11/28/2005 | EASTON, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 MERCERON MOHN R 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final evebril **Physician** Russ resulting in death) /Medical Due to (or as a consequence of) Examiner nom breest caronoma esks am Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) Examiner The law requires that the death certificate be executed animoma 12113 Due to (or as a consequence of the attending physician by Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ŏ Day Year 4☐Pregnant at time of death 5 Cher (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🔲 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 200 No ٩ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Pending investigation 2 🗌 No 1 Tyes 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide viithin 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760.

Stewart

Donald

DUTCHMAN'S CROWLEY MD 610 31. Date filed (Month, Day, Year) NOV 2 3 2005 Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

			1 - For State Registrar	State of Ma		partment of ertificate of		d Mental Hy	giene 005	39401
	Dhusia		1. Decedent's Name (First, Middle, Las	")				2. Date of Dea	ath	3. Time of Death
	Physic /Medi		ROBERT			SIX		11	29 2005	5:00 P M
	Exami	ner	4a. Facility Name (If not institution, give			4b. City, Town	n, or Location of De	eath	4c. County of De	ath
			FOREST HILL HEAL				REST HIL		HARFOR	ID
	Funeral Director		5. Social Security Number 6. Se 220–14–5854 Usual Residence of Decedent	X /. Ag M 2□F	e (In yrs. last birtho	Months Da		in. (Month, Da	y, Year)	irthplace (State or Foreig Country) [aryland
1	ow m		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
	E S	to	MD. Harf	ord			Fallsto	on		1 ☐ Yes 2 🛣 No
1	or 28s	Funeral Director	10e. Street and Number			10f. Zip Cod			10g. Citizen of What	Country?
1	23a	a	2019 Pleasan	tville H	Road		21047		United	States
4	lems lems	Inel	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	3. Was Decedent of If Yes, specify C	of Hispanic Origin?	(Specify Yes or No- erto Rican, etc.)		nerican Indian,
5	or i	by Fi	1 ☐ Never Married 2 ☐ Married ☐ 3 M Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> 11 If Yes, Give	No	1 □ Yes 2 🔀 1		,,	Specify:	
3	le in	ed E	15. Decedent's Edu	Year or Dates:	16a De	cedent's Usual Oc	cupation		16h Kind of Busines	White .
5 6	illed within 72 flours after beam with the Maryland Hygiene ther than "natural", or tems 23a or 28a-f show ant, It a Marsleul Evartinat must be rediffed at	Completed	(Specify only highest grad	le completed)	(G	ive kind of work do	ne during most of w	vorking	16b. Kind of Busines	s/industry
0000-01717	giene.	E O	Elementary/Secondary (0-12)	College (1-4or 5	)+)	Truck	Driver		Auto E	arts
2 3	al Hyginal	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,		
, de la company	and Mental B	To	William	Slade	Si	x	Elia	zabeth		Wilson
Wat yland	yes I and 2 should be light within 72 hours arien death with the maryfall to fleatht and Mental Hygiene. If tiem 27 is marked other than "natural", or fleams 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at		19a. Informant's Name/Relationship (T)						r, City or Town, State,	Zip Code)
	Health tem 27		R. Stephen Six	/Son		4 Conov	ingo Ro			d. 21014
Daiminore,	or of	1	20a. Method of Disposition 1	Removal from State	cemetery,	sposition (Name of crematory or other p		Date	20c. Location - City of	
			'4 □ Donation 5 □ Other (Specify)		St. Jo	hn's Ce	m. 12/	2/2005	Hydes, M	aryland
	Depar Important in		21. Signature of Euneral Sergice Ligens	n /ww		E.G. K	ress of Facility	arretts	ville, M eral Hom	arvland
			23a. Part1. Enter the disease, or complishock, or heart failure. List only o	ications that caused	he death. Do not					Approximate Interval Between
. +	กรูจเฉเลก	2 0	Immediate Cause (Final disease or condition	che	oles	4	,	- de		Onset and Death
	/Medical xaminer		resulting in death)	Due to (or as	a consequence of):		1000	1	- term	
	Adminici	<u>_</u>	Sequentially list conditions,	Due to /or so						
/ 5	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Classes or injury that initiated events	Due to (or as	a consequence of):					
6	af-tra	xar	that initiated events resulting in death) Last	Due to (or as	a consequence of):					-
cate be executed	physician and the burial-transit	dical		1						
		edic								
death codiff	attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome					23d. Date of de	elivery
1 400	0 0	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown		3 □Ectopic pregnar 5 □ Other <i>(specify)</i>			Month	Day Year
, t	by the stached	hys	9 🗆 Unknown							
ה ב מ	signed be de	by	Part II. Other significant conditions con	ntributing to death bu	ut not resulting in the	underlying cause	given in Part I.		bacco use contribute t es 2 □ No 3 □ P	
		etec								
The law require	has Je 2	ompleted						24a. Was a autops perforr	v prior to	utopsy findings available completion of cause of
		O	OF Management and the state of					1 ☐ Yes 2	2 No 1 □ Ye	s 2 No
Physician: T	certific lirector,	o Be	25. Was case referred to medical examiner?	lospital:	-t 0/750/0-1-1			eath (Check only on		J 11522-2
		$\vdash$	27. Manner of Death	1 ☐ Inpatie	y 28b. Time	of 28c. In	ury at		ence 6 Other (Spe	ecify)
Attending	ath. r: After e funer	atlo	Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injur		'ork? ⊒Yes 2 ⊒No			
		ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju	ary - At home, farm,	street, factory, offic	9	28f. Location (St.	reet and Number or F	ural Route Number,
2 2	ours after neral Dire filled in b	Cert		building, etc	. (Specify)			City or Town	i, Siare)	
A Hospital	Fur Bely	edical	29a. Certifier (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination and/or	ath occurred at the investigation, in my	time, date and place opinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
Toth	within 2 To the complet	Me	29b. Signature and title of certifier			29c. Lice	nse number	25	9d. Date signed (Mon	th, Day, Year)
,-			1 3 and 5 D			000	2755		Nous 1.	39,200
	1		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (Typ					- / - 5
	6		DR. DAVID DUNN,	615 W. MA	CPHAIL RO	AD, BEL A	IR, MD	21014		
	Sta	_	31. Date filed (Month; Day, Year)		r's Signature					
	Registr	ar	DEC DE 2	nos	Ro	Anath D				

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Registrar

30. Name ariu Dr. AFQC HYII.
31. Date filed (Monto, Day, Year)
DEC 0 6 2005 DHMH 17 Rev 1/2001

29b. Signature and title of centifier

a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625 hent Ave., Suite 102 cumberland, MD 21502

29c. License number

D1004/18

29d. Date signed (Month, Day, Year)

			For State Registrar	State of N	Maryland / [	Departmen Certificate			nd Me	ntal Hy	/giene Reg. No.	005	3940	3
3	Dhusisi		Decedent's Name (First, Middle						2	Date of D Month	eath Day	Year	3. Time of D	_
	Physicia /Medic	al .	KUTH.	SCHAF						11	26	12009		S AM
	Examin	er	4a. Facility Name (If not institution					Location of		1	40	County of Dea	th	
		5	MERCY ME					MOR		Data of P	I)	ALTI	MORE	Casaian
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last bir 71	Yrs. Months		Hours	Min.	Date of B (Month, D	ay, Year)		thplace (State or ountry)	
2	Director	-	172-28-2813 Usual Residence of Decedent		/1				I.	Mar.l	193	4 Alle	entown, PA	A
	/land		10a. State 10b. County		10c. City, Tow	n or Location							10d. Inside City	Limits
	Man	to	PA Lanc	aster	Lanca	eter							1 Tes	No No
	h the	Director	10e. Street and Number		101100	10f. Zip	Code				10g. Citiz	en of What C	ountry?	
	23a c		809 Dorsea Rd.			176	Ω1				US	Δ		
	sms sms	Funeral	11. Marital Status	12. Was Deceder Armed Forces	s?	13. Was Deced	tent of His	spanic Orig n, Mexican,	in? (Specif Puerto Ric	y Yes or Noan, etc.)	0- 1	<ol> <li>Race - Am Black, Whi</li> </ol>		
36	s atte	by Fu	1 Never Married 2 Marr 3 Widowed 4 Divorced	ied 1 Tes 2 If Yes, Give Year or Dates	No.	1 ☐ Yes	2 <b>/2</b> No	Specify:				Specify: Wh	nite	
5-0036	72 hours atter death with the Maryland naturel', or Iteme 23e or 28e-f show distal Executive Could be notified at		15. Decedent			Decedent's Usua	al Occupat	tion				nd of Business		
215	in 72 in na fedic	Completed	(Specify only highes	st grade completed)		(Give kind of worldife. DO NOT us	rk done du se retired)	uring most	of working				,	
212	s within jiene.	E O	Elementary/Secondary (0-12)	College (1-4o		cretary	Book	eeper			Rea	al Esta	ite Agend	ЗУ
	be filed tat Hygi d other svent, I	0	17. Father's Name (First, Middle,	Last)				18. Mother	's Name (F	First, Middle	a, Maiden	Sumame)		
Maryland	nould be I Mentat narked on natic sv	To B	Burton A. Kurtz	<u> </u>				Pan	sy M.	Ame	r			
ary	2 sholl and h		19a. Informant's Name/Relations	hip (Type, Print)	19b	. Mailing Address	(Street ar	nd Numbe	r or Rural P	Route Numi	ber, City or	Town, State,	Zip Code)	
	1 and 2 Health ssm 27		Clinton T. Scha	fer, Husbar	ed ,	809 Dors	ea R	d., I						
ore	Se to L		20a. Method of Disposition  **Darial 2 Cremation	3 ☐Removal from Stat	cemete	f Disposition (Nan ry, crematory or o	ther place		Dat			cation - City or		
Ë	Pag trment tant: Jury		4 Donation 5 Other (S		Miller	sville M				/2005	Mil.	lersvil	le, PA	
Baltimore,	permit. Page Department Important: If any injury o		Signature of Funeral Service	Button		22. Name an 234 W.			FIE	ed F. incast	Grofi er,P	f, Inc. 17603		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	ed the death. Do line.	not enter the mod	le of dying	, such as o	cardiac or r	espiratory	arrest,		Approximate Interval Betwee Onset and De	een
E	Physician		Immediate Cause (Final disease or condition	SEP	TIC SI	10CK							HOURS	-
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence	of):								
	LXammer	<u>.</u>	Sequentially list conditions, if any, leading to immediate	U	YROF		<u> </u>						DAYS	
$\sqrt{I}$	led Isit	Examiner	Cause (Disease or injury	\$ 5TA	GE II	1	1PU	OM	Δ				Marit	4
ν.	be executed icien and burial-transit	xar	that initiated events resulting in death) Last	Due to (or a	is a consequence	of):	(1)	010(1					. [010]	112
120	cate be executed physicien and the burial-transit	call		d										
89	ifficat g phy as th	edi							<u> </u>					
Box	eath certific attending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy 2 Petal death	3 ☐Ectopic pr	regnancy				2	3d. Date of de		
	Physician: The law requires that the death certificate this certificate has been signed by the attending phys ral director, page 2 should be detached for use as the	Physician/Med	in the past 12 menths? 1 ☐ Yes 12 ☐ No		at time of death	5 Other (sp						Month	Day Ye	ar
P.0	that the dened by the a	Phy	9 Unknown					-1-0-41		220 Did	tahaasa		a the serves of do	- th2
	uires that signed b	Ď	Part II. Other significant condition	CAN C		n the underlying c	ause give	n in Part I.			Yes 2		o the cause of dear	
ord	w require been si should l	ted	BREAST	UNNU	- 10				_	, ,	1163 2	140 0[],		KIIOWII
Records,	a law	Completed							_		opsy	24b. Were a prior to death?	utopsy findings av completion of cau	allable use of
E H	: The cate I									1 Yes	No	1 ☐ Ye	s 2□ No	
Vital	ician sertiti	Be	25. Was case referred to medical examiner?	Hospital:			Othe	-		Check only				
of	Phys this al dir	10	1 Yes 2 No	28a. Date of Ir	itient 2 ER/O		JA	4 🗆 Nui		5 □ Res d. Describe		Other (Spe	ecify)	
uo	ding h. Atter funer	tion	Natural 5 Pendin	ig (Month, L		njury M	28c, Injury Work 1 ☐ Y	? ′es 2 □ N		o. 0 0001100	11011 1111			
Division	Attending ir death. ector: Atter by the fune	fica	3 Suicide 6 Could	not be 28e. Place of	Injury - At home, fa	arm, street, factor	y, office		28				ural Route Numbe	B <i>r</i> ,
Ö	al or / s after I Dire d in b	Certification:	4 Homicide	building,	etc. (Specify)					City or 10	own, State)			
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely tilled in by the funeral director, page 2.	Medical (		ng Physician: To the be Examiner: On the basis and manner	of examination ar									
	To the within To the comple	Me	29b. Signature and title of certifie	r		290	c. License	number			29d. Date	signed (Mon	th, Day, Year)	
	. 2 - 0		* TKRTOL	plakia	· MD	J	00	633	326	,	11/2	6/2	005	
	ah		30. Name and address of person	who completed cause o	f death (Item 23a)	(Type, Print)								
	eff.		KUSH'R'S	HOLAKI	A, MI	D, MEI	RCY	MEI	DICA	LE	MTE	R BAL	TIMORE	MI
														_
- 1	Sta		31. Date filed (Month, Day, Year)		strar's Signature	Acres 1								
200	Sta Registi	ar -	DEC 0	6 2005	strar's Signature	foorte	0							

			1 - For State Registrar	State of Maryla		artment <i>rtificate</i>			ind Me		ene	05 39404
	Physici /Medio			BERT SIMMONS	, SR.					2. Date of Death Month	p Day 18 o	3. Time of Death 2005 11:27A M
	Examir	er	4a. Fecility Name (If not institution, give s  DOCTORS COMMUNITY			4b. City, T	own, or l		f Death		4c. County	y of Death <b>E GEORGES</b>
***	Funeral Director		Social Security Number 6. Sex	7. Age (In yi	rs. last birthday) 94 Yrs.	If Under 1 Months		If Under 2 Hours	Min.	8. Date of Birth (Month, Day, Jan. 3,		9. Birthplace (State or Foreign Country) North Carolina
	within 72 hours after death with the Maryland jiene. rthen "naturet", or Items 23a or 28a-1 show the Madical Examont must be to differ at	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince G  10e. Street and Number  2008 Del Sol Cou	eorges  rt  2. Was Decedent Ever in	City, Town or Lo	10f. Zip (		20721		ify Yes or No- ican, etc.)		10d. Inside City Limits  1
21215-0036	within Bne. then	Completed by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade		16a. Decec (Give life. L	f Yes, specification of Yes 2]  I are Yes 2]  I dent's Usual kind of work DO NOT use	Occupate done du retired)	Specify: ion iring most		1	Specif 6b. Kind of B	nck, White, etc.  Black Business/Industry  1road
and 2	be filed stal Hyg od othe event,	To Be Co	12 17. Father's Name (First, Middle, Last) John Simmons			i acr		18. Mother	r's Name (	(First, Middle, M		
iore, Maryland	Pages 1 and 2 should be nent of Health and Mental. int: If Item 27 Is marked o iry or other traumatic eve	Ť	19a. Informant's Name/Relationship (Type Vanessa Hardy / g 20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □ Relationship (Type Vanessa Hardy / g	randdaughter	2008 D. Place of Dispondemetery, crem	Del :	Sol ( e of her place)	Court	r or Rural Boy Da	Route Number, Wie, Mai	ryland Oc. Location	- City or Town, State
Baltimore,	permit. Page Deportment of Important: If any njury or onco.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License		t. James	. Name and	Address	of Facility	,			de Grace, MD ce, MD 21078
8760,	death certificate be executed  Wedical Examiner  Afor use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  a leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):							Approximate Interval Between Onset and Death Hours
.O. Box 68	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time o 9 Unknown	etal death 3	Ectopic pre						ate of delivery onth Day Year
rds, P.	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	tributing to death but not r	esulting in the ur	nderlying car	use giver	in Part I.		23e. Did toba	15	tribute to the cause of death?  3 □ Probably 4 □Unknown
Vital Records	The law ate has b page 2 sl	Completed			<del></del>					24a. Was an autopsy perform	eptiς	Were autopsy findings available prior to completion of cause of death?  1 \( \text{Yes} \) 2 \( \text{No} \)
of	ng Physici Iter this cei ineral direc	ıtlon; To Be	25. Was case referred to medical examiner?  1  Yes 2	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other c. Injury a Work?	4□ Nurs	sing Homi	Check only one e 5 ☐ Residen 3d. Describe how	ce 6 □Oth	
Division	al or Attendi s after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	thome, farm, streecify)	eet, factory,	office		28	Bf. Location (Stre City or Town,	et and Numb State)	ber or Rural Route Number,
	To the Hospital or Attervithin 24 hours after de To the Funeral Directo completely filled in by the	edical	29a. Certifier (Check only one) 2 Medical Examin	ician: To the best of my ker: On the basis of exami and manner stated.	nowledge, death	occurred at restigation, in	t the time in my opi	, date and nion, death	d place, an	nd due to the cau d at the time, dat	ise(s) and ma e and place,	anner as stated. and due to the cause(s)
	To the Comp	M	29b. Signature and title of certifier	1			License			296	d. Date signe	ed (Month, Day, Year)
,	G.		30. Name and address of person who ex	mpleted cause of death (III	tem 23a) (Type,		3/0			1	1)/10	7105
18	Sta	ite	Or. Bone 1/00 31. Date filed (Month, Day, Year)	Mercan-	tile A	Cane	<u> </u>	vite	134	Lar	90	11104 20774
	Registi		NOV 2 2 2005	cours s	good							

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Dewey Tunney Tolley 17, November 2005 /Medical 2:40 a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2540 Hoopers Island Road Fishing Creek Dorchester If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 16, 1927 Birthplace (State or Foreign Country) **Funeral** 1 M 2 □ F Yrs Director 215-20-2512 78 Maryland Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic evant, the Modical Example, institute the retilled at MD Dorchester Fishing Creek Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21634 2540 Hoopers Island Road USA Funeral 12. Was Decedent Ever in U.S. Amped Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Item any injury or other traumatic evant, the Medical Extra 1 Never Married 25 Married Saltimore. Maryland 21215-0036 1 ☐ Yes 2 X No þ Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) owner seafood plant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lee Dewey Tolley Hilda Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Tolley wife 2540 Hoopers Island Rd., Fishing Creek, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 11/21/05 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mule of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cambridge, MD 21613 Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or-as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to ( r as a conseque ce of): the attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not pesulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ lle 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifie 29d. Date sigged (Month, Day, Year) 30. Name and address of person strar's Signature State Registrar

				State of Marylan						
			1 - For State Registrar	otato of marytan		tificate of			Reg. No.	39406
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medi		Thomas William Tr	ego, Sr.				NOVEM &	Day Year	
	Examir		4a. Facility Name (If not institution, give si		/		r Location of Deat	h	4c. County of De	ath
				neral Hos	spital		ridge		Dorch	
	Funeral Director		5. Social Security Number 6. Sex 214-30-8389	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		9. B	irthplace (State or Foreign Country)
			Usual Residence of Decedent					UCL. 2,	1930 Mar	yland
_	anylan show	_	10a. State 10b. County		, Town or Lo	cation				10d. Inside City Limits
$\mathbb{C}$	8a-1 s	cto	Maryland Dorchester	Secr	retary					1 X Yes 2 □ No
X	with the	Dire	10e. Street and Number 115 Temple Street			10f. Zip Code 21664	<i>t</i> .		10g. Citizen of What C	Country?
3	leath ms 23	era		2. Was Decedent Ever in U.	S 13 V			Specify Ves or No-	USA 14. Race - Am	oriego Indian
0	or Ites	Fur	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 No Dat If Yes, Give Unkn	es "	Vas Decedent of H Yes, specify Cuba		to Rican, etc.)	Black, Wh	ite, etc.
ဗ္ဗ	ural',	d by	3 M Widowed 4 Divorced	Year or Dates: Unkn	lown 1	☐Yes 22 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-1 show its Mudical Examinat must be notified at	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade		16a. Deced (Give	ent's Usual Occup kind of work done o OO NOT use retired	ation during most of wor	rking	16b. Kind of Busines	s/Industry
7	within lene. then	d H c	Elementary/Secondary (0-12)	College (1-4or 5+)		/Operato			Marine Con	struction
פַ	il Hyg other	BeC	17. Father's Name (First, Middle, Last)						Maiden Sumame)	BETUCETON
<u> a</u>	uld be Menta Irked Itic ev	To B	Roland E. Trego				Mildr	ed Cathe	erine Colbo	ourn
Maryland	2 sho and I is ma		19a. Informant's Name/Relationship (Typ				and Number or Ru	ıral Route Numbe	r, City or Town, State,	Zip Code)
a`	l and fealth im 27 her tr		Patricia Jackson/Da		5537	Mt. Holly	Road, I		Market, M	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23s or 28s-1 show any injury or other treumatic event, the Medical Examinat must be notified at ance.		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Re	movar nom state		ition (Name of atory or other place			20c. Location - City o	
를	artmer artmer ortent injury		* 4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Ligensee			f Delmarva			elmar, Del	aware
Ba	Depa Impo any ir		* Semanel	Selles	1 10	Nimeand Address	erar Home	e, P. O.	Box 207 Market, MD	21621
		(	23a Party. Enter the disease, or complications, shock, or heart failure. List only one	ations that caused the death						Approximate
	Physician		Immediate Cause (Final disease or condition	Preumon						Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ence of):			-		
н	Lauminer	_	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ						
	uted s insit	Examiner	Cause (Disease or injury	Due to (or as a consequ	erice or).					
o o	be executed sician and burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a consequ	ence of):					
3760,	2 0	lical	d.							
	leath certifica attending phy I for use as th	Physiclan/Med	IF FEMALE:							
Box	attend for us	lan	in the past 12 months?	If yes, outcome of pregnan	death 3 □l	Ectopic pregnancy			23d. Date of de Month	livery Day Year
o.	at the de by the a	ysic	1 Yes 2 No 9 Unknown	4 Pregnant at time of de 9 Unknown	atn 5	Other (specify)				
ת. בי	The law requires that the tie has been signed by the vage 2 should be detached.	by Ph	Part II. Other significant conditions contr	ibuting to death but not resul	lting in the une	derlying cause give	n in Part I.	23e. Did tot	pacco use contribute to	the cause of death?
ecords,	w require been sig should b	ed b						1 □ Y€	es 2□No 3□P	robably 4 Unknown
မင	law ri as be	Completed						24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
		Con						perform	ned?   death?	2 No
Vital	Physiclen: rthis certificaral director,	Be	25. Was case referred to medical examiner?	spital:		Otho	_	th (Check only on		
ō	Phy this al d	. To	1 Yes 2 No	192 Inpatient 2 L E	P/Outpatient 28b. Time of		4 🗀 Nursing no		once 6 Other (Spe	cify)
on	nding th: :: Afte s fune	itlor	1 Accident 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injury Work	? ′es 2 □ No	20d. Describe no	w injury occurred	
DIVISION	or Attending ifter death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon	ne, farm, stree	at, factory, office		28f. Location (St	reet and Number or Ri	ural Route Number,
	itel or rs afte rel Dii	Cer		building, etc. (Specify)				City or Town		
	To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  1 Certifying Physic 2 Medical Examine	ian: To the best of my know r: On the basis of examination and manner stated.	rledge, death on and/or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the cared at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	cod 1 1 1	15	29c. License			9d. Date signed (Mont	
/			· wyw			0006	:1822		11/15/2	005
1			30. Name and address of person who com	olmater N	23a) (Турв, Р 1, 0	503 B	yrn St	. Com	bridge, 1	005 MO ZIG 13
I	Sta Registra	te	31. Date filed (Month, NOVar)1 8 2	005 <sup>32. Regultrar's Signatu</sup>	Ire K	bout ,				
	. icgisti	- 1		1	- 19					

State of Maryland / Department of Health and Mental Hygier 00539417 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** NOV. 12, 2005 Year 2:00a M Vasquez /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5114 Parklawn Terrace #102 Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/14/1956 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2 🛣 F 49 Guatemala Director 214-71-7788 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show the Medical Exercine roust be notified at Md Rockville Montgomery 1 Tyes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 5114 Parklawn Terrace #102 20852 "natural", or Items 23a Guatemala Funerai 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1₺ Yes 2☐ No Specify: White ģ 3 Widowed 4 Divorced Guatemalan Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury, or other traumatic excess. Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Chef injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Oscar Alvarado Isabel Jimenez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 19a. Informant's Name/Relationship (Type, Print) Diana Vasquez/Daughter 5114 Parklawn Terrace #102 Rockville, Md 20b. Place of Disposition (Name of cometer), crematory or other processing the complete company of the company of the co 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Guatemala City, Guatemala \* 4 □ Donation 5 □ Other (Specify) 11/23/05 21. Signature Funeral Service PHILIP D. RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gastric Cancer /Medical Due to (or as a consequence of) Examiner Bile Duct Cancer Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Box 68760 attending physician Physician/Medicai as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the at d be detached fo 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phye within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Nov.18,2005 DC M033109 30. Name and address of rson who co in eted cause of death (Item 23a) (Type, Print) 3800 Reservoir Rd.NW Wash, D.C. JIMMY/ HWANG 31. Date filed (Month, Day, Year), 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of H			iene 0 0	5 39408
	Physic	ian	1. Decedent's Name (First, Middle, Las	st)				2. Date of Death		3. Time of Death
	/Medi	cal	Harry Charles We					11	_18	05 1:45 P M
1	Exami	ner	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, or		1	4c. County o	
	Funeral		Holy Cross Hospi 5. Social Security Number 6. Se		(In yrs. last birthday	Silver If Under 1 Year	Spring If Under 24 Hrs.	8. Date of Birth		gomery
ì	Director			<b>Ø</b> M 2□ F	O Yrs.	Months Days	Hours Min.	(Month, Day, 09-24-	Year) 45	Birthplace (State or Foreign Country)     DC
	laryland show		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	a-fst	ctor	MD Prince G	eorges	Upper M	lar1boro				1 ∑ Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number			10f. Zip Code		10	ng. Citizen of Wh	nat Country?
	ath w	rai	10608 Mary Carrol			2077			US	
	er de Itam	une	11. Marital Status	12. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)		- American Indian, White, etc.
21215-0036	within 72 hours after death with the Maryland ane. sne. than "natural", or Itams 23e or 28e-1 show then "natural" or Itams 28e or 28e-1 show as Medical Evertiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 📉 N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 ☒ No	Specify:		Specify:	Black
5-0	72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	ucation	16a. Dece	dent's Usual Occupa	tion	king 1	6b. Kind of Busi	iness/Industry
121	vithin ne. han "	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+)	kind of work done do DO NOT use retired)	bring most or worr	ang .		
2	2 should be filed withir and Mental Hygiene. Ia marked othar than aumatic evant, Ite M		12 17. Father's Name (First, Middle, Last)		Cle:		10 11-11-1	ne (First, Middle, M		ernment
Maryland	buld be f Mental H arked of atic eva	Be c		talah Cra					,	)
7	should ind Men a marke umatic	2	Harry Charles W		19b. Maili	ng Address (Street a.		ra Copela m <i>l B</i> oute Number		tate Zin Code)
Baltimore, N	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If itam 27 Ia marked othar than "natural", or Itams 23a or 28a-1 show any injury or othar traumatic event, I're Medical Evantiner must be notified at 2008.		Barbara Welch/W  20a. Method of Disposition  1 \mathbb{N} Burial 2 \subseteq Cremation 3 \subseteq  4 \subseteq Donation 5 \subseteq Other (Specify  21. Signature of Funeral Service Licen	Removal from State	20b. Place of Dispo cemetery, crea Lincoln	sition (Name of matory or other place	11-	Date 2 25-05 S	oc. Location - C	boro MD 2077 ity or Town, State  MD  Services
<u> </u>	80 = 80		23a. Part1. Enter the disease, or comp	trickla	nd 6	500 Allent	town Road	d, Camp S	prings,	
8760,	/Medical Examiner bhysician and bhysician and sthe purial-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. End of ships, Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Cardiac Due to (or as a c.	Encephala consequence of):  Arrest consequence of):  consequence of):	pathy				Onset and Death
.O. Box 6	the death certif y the attending iched for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
Φ.	es that igned b be deta	by Pł	Part II. Other significant conditions co	ontributing to death bu	t not resulting in the u	nderlying cause giver	n in Part I.	23e. Did toba	acco use contribu	ute to the cause of death?
ord	w requir been si should							1 🗆 Yes	2 X No 3	☐ Probably 4 ☐Unknown
Vital Records,	The la ate has page 2	e Completed	25. Was case referred to medical						ed? dea XINo 1□	re autopsy findings available or to completion of cause of th? I Yes 2□ No
	Physician: this certific ral director,	0 8	examiner?	Hospital:	t 2 ER/Outpatien	Other		h Check only one		(Specify)
J Of		T :u	27. Manner of Death	28a. Date of Injury (Month, Day	28b. Time of			28d. Describe how		
sior	Attanding Ir death. actor: After	atio	1 XNatural 5 Pending 2 Accident investigation	(Worth, Day	Year) Injury		es 2 □No			
Division		Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,		or Rural Route Number,
	To tha Hospital or within 24 hours after To tha Funeral Discompletely filled in	Medical (	29a. Certifier 1 X Certifying Phy (Check only one) 2 Medical Exam	rsician: To the best of iner: On the basis of and manner state	examination and/or inv	occurred at the time restigation, in my opin	o, date and place, nion, death occurr	and due to the cau red at the time, date	ise(s) and manne e and place, and	er as stated. I due to the cause(s)
	To tha within 2 To tha complet	M	29b. Signature and title of certifier	10		29c. License	number	290	d. Date signed (#	Month, Day, Year)
)	6		100180	Who	_	D005	3850		11-18	-05
	3)		30. Name and address of person who c	ompleted cause of de	ath (Item 23a) (Type,	Print) Holy (	Cross Hos	spital		
	AC A CASSELL			hwartz	1500	Forest Gl	len Road	, Silver	Spring,	MD 20910
	Sta Registr		31NOV 2 2 2005	32. Registrar	S SION IUI B					

			For State Registrar	State of Maryland		artmen rtificat			and Mer		ene g. Kro.	5	39409
	Physici	20	1. Decedent's Name (First, Middle, Last)							Date of Death Month	Day	Year	3. Time of Death
	/Medic		Daisy Mari				-			ovember	16, 20		8:59 A M
20	Examin	er	4a. Facility Name ( <i>If not institution, giv</i> e st Washington Adventi					r Location o Park	of Death		,	or Death tqome	rv
	Funcial	2	5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under		Date of Birth			ace (State or Foreign try)
W	Funeral Director	d de la constante de la consta	577-42-5861	<sup>4</sup> 2X□ F 76	Yrs.	Months	Days	Hours		(Month, Day, oril 2,	1929	Maryl	and
	D >		Usual Residence of Decedent  10a. State 10b. County	10c Cib	v. Town or Lo	ocation						10	Od. Inside City Limits
	faryla ahov	5			,								1 ☐ Yes 2 No
	28a-f	Directo	Maryland Prince Ge	orges ny	attsv.	10f. Zip	Code			10	g. Citizen of W	Vhat Coun	try?
	3a or		5805 Queens Chapel	Road				207	82		U.S	SA	
	death ms 2	Funeral		. Was Decedent Ever in U.	S. 13.	Was Dece	dent of H			Yes or No- an, etc.)	14. Race	e · America	
9	or its	by Fu	1 Never Married 2 Married	Armed Forces?  1  Yes 2 No If Yes, Give		1 🗆 Yes		Specify:			Specify		
21215-0036	72 hours after death with the Maryland natural; or items 23s or 28s-f show dical Examinar must be notified at	q pa	3 X Widowed 4 ☐ Divorced  15. Decedent's Education	Year or Dates:	16a Dece	dent's Usu	al Occup	ation		1	6b. Kind of Bu		
75	n "na	piet	(Specify only highest grade  Elementary/Secondary (0-12)		(Give	kind of wo DO NOT u	rk done	during most	t of working				
212	d within giene. er then *	Completed	11	College (1-407 3+)	Boo	okkee	per				Depart		Store
	be filed tal Hygi d other	Be (	17. Father's Name (First, Middle, Last)								aiden Sumam		
yla	ould I Ment	은	Richard Elzzie Dem		405 14-10		(644				rude Je		
Maryland	12 sh h and 7 ls m traum		19a. fnformant's Name/Relationship (Typ Mary E. Mitchell -			-					le, MD		
	ges 1 and 2 should be filed within 72 hours after death with the Marylan to Health and Mental Hyglene. If Itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic avent, the Mudical Examinar must be notified at		20a. Method of Disposition	20b. P	Place of Dispo	sition (Na	me of		Date		Oc. Location -		
Baltimore,	S = = >		1 Donation 5 ☐ Other (Specify)	moval from State					11-21-	2005 C	linton	. MD	
alti	말투를 숨.		21. Signalure of Funeral Service Sicense		-			ss of Facilit	_		Box 156		
Ö	Depermination of the permitted of the series		Mart M. Sw	Lower							, MD 20	0604-	0156
nj.			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the deatl caus on each line.	h. Do not en	ter the mod	de of dyir	ng, such as	cardiac or re	spiratory arre	st,		Approximate Interval Between Onset and Death
	Pnysician	8 7	Immediate Cause (Final disease or condition resulting in death)	HSplrah.	m/	29	eur	nos	119			×	24 425.
	/Medical Examiner		1	Du no (or s a conseq	uence of):	Ro.	mal	hit	15.			_	Vecas
	**	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):	1	Cric	11/				-/	years.
	be executed sician and burial-transit	Examiner	that initiated events c.	Pulm	ma	re	00	de	ew	9		>	4 days.
0,	be executed ician and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):	0							
8760	9 8	dical	d.										
89 X	death certifica e attending ph id for use as th	Physician/Med	IF FEMALE: 23	c. If yes, outcome of pregna	ancy						23d Dat	e of delive	arv.
Вох	atten 1 for u	cian	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		⊒Ectopic p ⊒ Other (s)		У			Mor		Day Year
0	at the de by the a	hysi	9 Unknown	9☐ Unknown									
S, D	The law requires that the site has been signed by the bage 2 should be detached.	by P	Part II. Other significant conditions conf	nbuting to death but not res	ulting in the u	underlying	cause gr	en in Part I		_	4-6		ne cause of death?
ord	w require		un contro	ned 1	nac	ere	2		1	1 □ Ye	s 25 No	3 Prob	ably 4 Unknown
ec	e law r has be	Completed	Atrial of	Brilah	on.					24a. Was an autopsy perform	/ p	Were auto prior to cor death?	psy findings available inpletion of cause of
<u>e</u>		ខ	γ							1□ Yes 2	XNo 1		2□ No
Vital Records,	Physicism: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	ospital:	ER/Outpatie	at 200	OA Ott	205		heck only one		ar /Saash	ut.
of	ig Physical dispersal di	H	1 Yes 2 40	28a. Dale of Injury	28b. Time o		28c. Inju	4   140			nce 6 Other		<i>y)</i>
ion	들는 중 출	atio	1 Adatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М		rk? ]Yes 2 ☐	No				
Division	or Attendated Director:	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	treet, factor	ry, office		28f	Location (Str City or Town		er or Rura	l Route Number,
Q	urs af	Cel	no number 10 forms	telepis To a bour of manager	materian to	th see as	t salt about the	nsh data co	of steel are	Colonia de Calendario de la	unidat ne far-	Marie of the	hatel
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Certification:		er: On the basis of examina and manner stated.									
	omple	Me	29b. Signature and title of certifier	000		29	c. Licens	se number		29	d. Date signed	d (Month,	Day, Year)
	- > - 0		* Kamaa k	· Tali			019	609	7	1	1.16-6	35.	
(			30. Name and address of person who co	noleted cause of death (Iter	n 23a) (Type	, Print)	20	MA	N. X	? T	ULI.	141)	)
	DBG		31. Date filed (Month, Oay, Year)	32. Resistrar's Signa	ount	Kain	168	- M	1) 20	0712	•		
	St Regist	ate	NOV 1 8 20	105 Jacob	K.	board	0						

DENA ALSUP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygi

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ea. No.	U	U	W	U	J	-7	ł

		1 - State Registrar		Certificate of Death	Reg.	2005 39410
Phys	ician	1. Decedent's Name (First, Middle, La	116.0	)	2. Date of Death	Day Year 3. Time of Death
A	dical	Dena		′	NOVEMBER	30 2003
Exan	niner	4a. Facility Name (If not institution, gire		4b. City, Town, or Location of Dea	ath .	4c. County of Death
- Funer	. # 51	5. Social Security Number 6.	Sex 7. Age (In yrs. last birt	hday) If Under 1 Year   If Under 24 Hr	s. 8. Date of Birth	9. Birthplace (State or Foreign
Directo		220-20-5739	THE OPE	Yrs. Months Days Hours Min	S. 8. Date of Birth (Month, Day, Yea April 12, 19	128 Virginia
land		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
death with the Maryland ms 23e or 28a-f show frivest be notified at	tor	md	NA	Baltimore	,	1XYes 2 No
h the	Director	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Country?
23e c			une Rd.	212-25		USA
er dez	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.
Iryland 21215-0036 should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "naturel", or Items 23e or 28e-1 show imatic event, the Medical Examiner is ust be notified at	þ	3 Widowed 4 □ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify: Black
5-0 72 ho	etec	15. Decedent's E (Specify only highest gr	ducation 16a.	Decedent's Usual Occupation (Give kind of work done during most of w	orking 16b.	Kind of Business/Industry
2121 1 within liene. r than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Factures wm	4-	Luggage Company
e filed at Hygin other	BeC		)	18. Mother's No	ame (First, Middle, Maid	
aryiar should b and Ments marked umatic e	ToE	FairField	Corprue	Cor	Stance	White
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event		19a. Informant's Name/Relationship		Mailing Address (Street and Number or F	1 . 1	
Health		20a. Method of Disposition	daughter 90	16 St. Dunstens 1 Disposition (Name of		md, 21212 Location - City or Town, State
Baltimore, Dermit. Pages 1 are Department of Heal mportent: If Item any injury or othe		1 Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	v. crematory or other place)	200.	usdoune, md.
Baltim permit. Pag Department Importent: I	ģ	21. Signature Fun ral Service Lige	"	22. Name and Address of Facility 270 Fred H		
D POPE	ä	1 dans	1 Loud	Gen. P. march 13	meral don	e Baeto, md. 21229
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death. Do none cause on each line.	ot enter the mode of dying, such as cardi		Approximate Interval Between
Physicia	n	Immediate Cause (Final disease or condition	PROBABLE	MYOCARDIAL:	INFARC.TI	
/Medica Examine		resulting in death)	Due to (or as a consequence of			
		Sequentially list conditions, if any, leading to immediate	bbue to (or as a consequence of	f):		
uted	Examiner	cause. Enter Underlying Cause (Disease or injury		.,,		
O, exect en and rial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a consequence of	f):		
68760, flicate be executed physicien and as the burial-transit	Medicai		d			
X 68 sertifica ding pt	Med	IF FEMALE:	00.16			
BOX eath cert attendin Ifor use	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death	3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
G at a gent	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	5 Other (specify)		
S, P es that igned b	by Pl	Part II. Other significant conditions	contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
VITAI RECOYGS, sician: The law requires t certificate has been signe	ed b				1 Tes	2 No 3 Probably 4 Unknown
law ra	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
I Hec The lav cate has	Con				performed?	death?
VITAL IN tician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		ath (Check only one)	
Phys r this	1.70	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ER/Out 28a. Date of Injury 28b. Ti	patient 3 DOA Other: 4 Nursing	Home 5 Residence	
DIVISION OF the of Attending Physical director: After this din by the funeral directorial directorial directorial directorial directorial directorial directorial directorial directorial directorial directorial directoria	Certification:	1 Natural 5 Pending 2 Accident investigatio	(Month, Day Year) In	ime of 28c. Injury at jury Work?  M 1 ☐ Yes 2 ☐ No	253. 2530.135 1104 111	ary occurred
DIVISIO If or Attendi efter death, Director: A	tifica	3 Suicide 6 Could not be determined		m, street, factory, office		and Number or Rural Route Number,
spital or nours efter neraf Die filled in					City or Town, Sta	
DIVISION Of VITA  To the Hospital or Attending Physician: within 24 hours lefter death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	nysician: To the best of my knowledge, miner: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occ	e, and due to the cause( urred at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
To the Howithin 24 h To the Fur	Me	29b. Signature and title of certifier	. 01	29c. License number		ate signed (Month, Day, Year)
		Tenau	1 Jaken	W5857	o place	15mber 30, 2005
3			completed cause of death (Item 23a)	Type, Print) 5601 LocH	RAVEN &	IEMBER 30, 2005 BOULEVARD AND LIZ39
			PAKER, 11D	BAKTIMOR	E, MARYK	AND 21239
Regis	State strar	31. Date filed (Month, Day, Year)	32. Registrate Signature	5 Sparle		
DHMH 17 Rev	4,4	ひとし (	LOUST STREET S	a proces		

State of Maryland / Department of Health and Mental Hygienes

Certificate of Death

Reg. No.

November 23, 2005

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agnew, mary

For State Registral

Andre Brown    Andre Brown   December   1, 2005   7:19 A		4	State Registrar	distalla di a si	41		Certificate of	of Death		eg. Ne.	005	3941
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The content of the			a. Facility Name (If not insti				4b. City, Tow	n, or Location of Dea				1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
20. Social Security Numbers   6. Sec.   10. Country   2 / Age (large register)   1 / 10 / 10 / 10 / 10 / 10 / 10 / 10			753 Lennox S	treet			Ba	altimore				
10a. Slame   10a. County   10b. County   10c. City from or Location   10c. Size Code   10c. Size can define the county   10c. Size can defin							irthday) If Under 1 Y	ear If Under 24 Hr	8. Date of Birth (Month, Day 05/14/	1957	9. Birth Col	nplace (State or Fountry)
Temporary   Temp		-				10a City Tay	un as Lacation					404 1 21 02 11
23. Signature of Funeral Service Licensee  24. Name and Address of Facility Cremation and Princeral Atternatives S717 Green Pastures Drive Baltimore, Maryland 25. Name and Address of Facility Cremation and Princeral Atternatives S717 Green Pastures Drive Baltimore, Maryland 25. Name and Address of Facility Cremation and Princeral Atternatives S717 Green Pastures Drive Baltimore, Maryland Approximate Approximate Atternative List only one cause on each line.  25. Port 1 Sing the Registrative List only one cause on each line.  25. Sequentially is conditions.  25. Sequentially is conditions.  25. Sequentially is conditions.  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  25. Due to (or as a consequence of):  26. Due to (or as a consequence of):  27. The prince of t	5			unty								1 ⊠Yes 2 □
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Immediate Cause (Final disease or condition (seath)   Due to (or as a consequence of):	ä		The second secon	ne R	the Mo	1443	8717 Gre	en Pastures	Drive Ba	altım		ryland
Due to (or as a consequence of):    Due to (or as a consequence of):		1	<ol> <li>Part1. eter the diseas shock, or heart failure.</li> </ol>	se, or comp List only of	lications that cause one cause on each li	d the death. Do	not enter the mode of	dying, such as cardi	ac or respiratory arm	est,		Interval Between
Due to (or as a consequence of):  Sequentially list conditions, cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause. Enter Underlying Cause Disease or Injury that inflated events resulting in death) Last    IF FEMALE: 23b. Was deceded in pregnant in the past 12 months?   1   Ves 2   No 9   Unknown   1   Live birth 2   Felal death   5   Other (specify)   Month Day Yea   Pregnant at time of death   5   Other (specify)   Month Day Yea   1   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death   1   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death   1   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death   1   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death   1   Other significant conditions contribute to the cause of death   1   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death   1   Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   23e. Did tobacco use contribute to the cause of death   1   Other significant conditions contribute to the cause of death   1   Other significant   1   Other significant   1   Other significant   1   Other significant   1   Other significant   1   Other significant   1   Other significant   1   Other significant   1   Other significant   1   Other significant   1   Other significant   1   Ot		(	disease or condition		LV	ND (	ancer	~				
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Due to (or as a consequence of):    FEMALE:   23b. Was decedent pregnant in the past 12 months?		9										
Due to (or as a consequence of):    The part of the past 12 months?   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   23d. Date of delivery   Month   Day   Yea   24d. Was an autopsy findings ave print to completion of caus   24d. Was an autopsy findings ave print to completion of caus   24d. Was an autopsy   24d. Was		- 0	Sequentially list conditions,		b. Due to for the	A CONSTRUCTOR	offe					
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24a. Was an autopsy performed? 1   Yes   2   Mo   25. Was case referred to medical example? 1   Yes   2   Mo   25. Was case referred to medical example? 1   Yes   2   Mo   26. Place of Death (Check only one)  27. Manner of Death   1   Inpatient   2   ER/Outpatient   3   DOA   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   M   1   Yes   2   No   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   M   1   Yes   2   No   28b. Place of Death   28c. Injury at Work?   28c. Describe how injury occurred   28c. Place of Death   28c. Location (Street and Number or Rural Route Number of the City or Town, State)  28c. Place of Injury   28c. Location (Street and Number or Rural Route Number of Town, State)  28c. Place of Injury   28c. Location (Street and Number or Rural Route Number of Town, State)  28c. Place of Injury   28c. Location (Street and Number or Rural Route Number of Town, State)  28c. Place of Injury   28c. Location (Street and Number or Rural Route Number of Town, State)  28c. Place of Injury   28c. Location (Street and Number or Rural Route Number of Town, State)  28c. Place of Injury   28c. Location (Street and Number or Rural Route Number of Town, State)  28c. Place of Injury   28c. Location (Street and Number or Rural Route Number of Town, State)  28c. Location (Street and Number or Rural Route Number of Town, State)  28c. Location (Street and Number or Rural Route Number of Rural Route Number of Town, State)	20	ľ	F FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 Yes 2 No 9 Unknown	nt	c. Due to (or as  d	e of pregnancy 2 Fetal death	e of): h 3 □Ectopic pregn. 5 □ Other (specif)	")	23a Did tol		Month	Day Year
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27. Manner of Death 1 Matural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury 4 Home, farm, street, factory, office 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 27. Manner of Death 1 Matural 28d. Describe how injury occurred 28d.	Completed by Physician/Medical	P	F FEMALE: 23b. Was decedent pregnar in the past 12 months? 1  yes 2  No 9  Unknown	nditions oc	c. Due to (or as  d	e of pregnancy 2 Fetal death	e of): h 3 □Ectopic pregn. 5 □ Other (specif)	e given in Part I.	1 24a. Was a autops perforr	bacco using the symmetry of th	Month e contribute to No 3 Pro 24b. Were aut prior to codeath?	Day Year the cause of death bably 4 [Unkn opsy findings avail ompletion of cause
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	Completed by Physician/Medical	P	FFEMALE: 23b. Was decedent pregnar in the past 12 months? 1   Yes 2   No 9   Unknown art II. Other significant context in the sig	adical and and and and and and and and and and	Due to (or as  d	e of pregnancy 2 Fetal death time of death out not resulting	h 3 Ectopic pregn. 5 Other (specif) in the underlying cause  outpatient 3 DOA Time of 28c.	26. Place of Di Other: 4 \( \subseteq \text{Nursing} \) nury at Work?	24a. Was a autops perform 1   Yes 2 aath (Check only on Home 5   side	bacco using the symmetry of th	Month  e contribute to  No 3   Pro  24b. Were autriprior to cidaath? 1   Yes  Other (Special Control of the Con	Day Year the cause of death bably 4 □Unkni opsy findings avail ompletion of cause
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29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	To Be Completed by Physician/Medical	P	F FEMALE: 23b. Was decedent pregnar in the past 12 months? 1   Yes 2   No 9   Unknown 2art II. Other significant conexammer? 1   Yes 2   No   25. Was case referred to me exammer? 1   Yes 2   No   26. Wanner of Death	ending vestigation ould not be	c. Due to (or as d	e of pregnancy 2 Fetal death time of death out not resulting ent 2 FR/O	h 3 Ectopic pregn. 5 Other (specify) in the underlying cause  butpatient 3 DOA Time of linjury M	26. Place of Dr Other: 4 \sum Nursing niury at Work? 1 \sum Yes 2 \sum No	24a. Was a autops perform 1 Yes and Check only on Home 5 L side 28d. Describe ho	bacco using symmed? 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Month  e contribute to  No 3 Pro  24b. Were aut prior to c death? 1 Yes	Day Year the cause of death bably 4 [Unkn opsy findings avail ompletion of cause 2 [Incompletion of cause
	Completed by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnar in the past 12 months? 1   Yes   2   No   25. Was case referred to me exampler? 1   Yes   2   No   27. Manner of Death 1   Matural   5   P   2   Accident   in   3   Suicide   6   C   4   Homicide   Certifier   10   Certifier   29a. Certifier   10   Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier   10   Certifier   20a. Certifier	ending vestigation ould not be alermined	Due to (or as d	e of pregnancy 2 Fetal deat t time of death out not resulting ent 2 ER/O ory ay Year) 28b. jury - At home, fic. (Specify)	h 3 Ectopic pregn. 5 Other (specify) in the underlying cause butpatient 3 DOA Time of 28c. Injury M larm, street, factory, off	26. Place of Do Other: 4 \_ Nursing niury at Work? 1 \_ Yes 2 \_ No ice	24a. Was a autops perform 1 Yes : eath (Check only on Home 5 Side 28d. Describe how 28d. Describe how 28d. Location (St. City or Town	bacco using symmetreet and n, State)	Month  e contribute to  No 3 Pro  24b. Were autorior to codeath? 1 Yes  Other (Special Control occurred)  Number or Ruind manner as	Day Year the cause of death bably 4 □Unkn opsy findings avai ampletion of cause 2 □ No ify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Completed by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnar in the past 12 months? 1   Yes 2   No 9   Unknown art II. Other significant context in the sig	ending vestigation obeletmined	Due to (or as d	ent 2 ER/C  Liry Ly Year)  of my knowledg of examination a	h 3 Ectopic pregn. 5 Other (specify) in the underlying cause butpatient 3 DOA Time of linjury M farm, street, factory, off	26. Place of Dr Other: 4 Nursing niury at Work? 1 Yes 2 No ice	24a. Was a autops perform 1 Yes 28d. Describe how 28d. Describe how 28d. Location (SI City or Town 29, and due to the courred at the time, d	bacco using the symmetry of th	Month  e contribute to  No 3 Pro  24b. Were aut prior to c death? 1 Yes  Other (Spec occurred	the cause of death bably 4 □Unkn opsy findings avai ompletion of cause 2 □ No ify)  ral Route Number, stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Completed by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnar in the past 12 months? 1   Yes 2   No 9   Unknown art II. Other significant context in the sig	ending vestigation obeletmined	Due to (or as d	ent 2 ER/C  Liry Ly Year)  of my knowledg of examination a	h 3 Ectopic pregn. 5 Other (specify) in the underlying cause butpatient 3 DOA Time of linjury M farm, street, factory, off	26. Place of Dr Other: 4 Nursing niury at Work? 1 Yes 2 No ice	24a. Was a autops perform 1 Yes : eath (Check only on Home 5 State 28d. Describe how 28d. Describe how 28d. Location (State 28d. City or Town 28d. and due to the courred at the time, d	bacco using the part of the pa	Month  e contribute to  No 3 Pro  24b. Were aut prior to c death?  1 Yes  Other (Spec occurred  Number or Rui	the cause of death the cause of death shably 4 □Unkn opsy findings avair ompletion of cause 2 □ √ o o o o o o o o o o o o o o o o o o
	Completed by Physician/Medical	P 2	FFEMALE: 23b. Was decedent pregnar in the past 12 months? 1   Yes 2   No 9   Unknown art II. Other significant context in the sig	ending vestigation obeletmined	Due to (or as d	ent 2 ER/C  Liry Ly Year)  of my knowledg of examination a	h 3 Ectopic pregn. 5 Other (specify) in the underlying cause butpatient 3 DOA Time of linjury M farm, street, factory, off	26. Place of Dr Other: 4 Nursing niury at Work? 1 Yes 2 No ice	24a. Was a autops perform 1 Yes : eath (Check only on Home 5 State 28d. Describe how 28d. Describe how 28d. Location (State 28d. City or Town 28d. and due to the courred at the time, d	bacco using the part of the pa	Month  e contribute to  No 3 Pro  24b. Were aut prior to c death?  1 Yes  Other (Spec occurred  Number or Rui	the cause of death shably 4 Dunkr opsy findings avail ompletion of cause 2 A no stated.  The cause Number, stated. The cause (s) A no stated.

		For State Registrar	State of Maryland	•	ent of Health and cate of Death		2.005 39413
Physici /Medic		1. Decedent's Name (First, Middle, Last) Emma Bo	16e			2. Date of Death DECEMBE	R <sup>ay</sup> E, 2 <b>005</b> 3. Time of Death 4:35 PM
Examin		4a. Facility Name (If not institution, give s Saint Joseph M	treet and number) edical Cent		City, Town, or Location of Deat		4c. County of Death Baltimore
Funeral Director		40-10-8182	7. Age (In yrs. i		nder 1 Year If Under 24 Hrs ths Days Hours Min.		9. Birthplace (State or Foreign Gountry)  9. Wew York
Maryland f show	or	Usual Residence of Decedent  10a. State  10b. County	10c. City	Town or Location			10d. Inside City Limits 1 💢 es 2 □ No
death with the Maryland me 23a or 28a-f show rmust be notified at	Director	10e. Street and Number	. A		X <i>Ore</i> 2/1/3	10g	. Citizen of What Country?
fter death r iteme 23	Funerai	11. Marital Status  1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No	If Yes,	recedent of Hispanic Origin? (S specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
within 72 hours after ene. then "natural", or ite then "natural", or ite medical Examine	by	3 ☐ Widowed 4 € Divorced  15. Decedent's Educ		16a. Decedent's	es 2 No Specify:  Usual Occupation	16	b. Kind of Business/Industry
d within 7 giene.	Completed	(Specify only highest grade	College (1-4or 5+)	life. DO No	of work done during most of wa OT use retired) MESHC	rking	Private
Maryland 21213-UU36 d 2 should be filed within 72 hours after death with the Marylan th and Manual Hygiene. It is marked other then "natural", or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at	To Be (	17. Father's Name (First, Middle, Last)	YD.		18. Mother's Na	me (First, Middle, Ma	iden Sumame) Lums
2 8 5 5 7 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		19a. Informant's Name/Relationship (Ty	ingleton	2753	ress (Street and Number or R	re Bal	City or Town, State, Zip Code)
A 0 0 1		20a. Method of Disposition  1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	emoval from State	lace of Disposition emetery, crematory	or other place)	Date 20	c. Location - City or Town, State
Baltimo permit. Page Department of important: if any injury or		21. Signature of Funeral Service License		J 22 Nam Vac 490	e and Address of Facility	eve tu	MD 7/317
Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	cations that caused the death to cause on each line.			c or respiratory arrest	Approximate Interval Between Onset and Death
/Medical Examiner	P	resulting in death)  Sequentially list conditions,	Due to (or as a consequEHRONIC OB		VE LUNG DIS	EASE	
cuted	Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ	Jence of):			
58760, icate be executed physicien and s the burial-transit	dicai Ex	resulting in death) Last	Due to (or as a consequ	uence of):			
I Records, P.O. Box 68/6U,  The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	an/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregna 1□Live birth 2□Fetal	death 3 Ecto	oic pregnancy		23d. Date ol delivery  Month Day Year
that the decided by the a	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at time of de 9☐ Unknown		or (specify)		,
Records, F he law requires tha e hes been signed I age 2 should be det	ρ	Part II. Other significant conditions cor	induting to death but not rest	uiting in the underly	ing cause given in Part I.	1 ☐ Yes	cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown
I Kec	Completed					24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 No
of Vita Physician: rthis certifice ral director,	To Be	25. Was case referred to medical examiner?	ospital: 1 Xinpatient 2 🗆	ER/Outpatient 3	Other	ath Check only one	te 6 □Other (Specify)
Division of Vital i or Attending Physicien: 1 effer death. Director: After this certificel d in by the funeral director.		27. Manner ol D ath 1 SNatural 5 Pending 2 Accident investigation	28a. te ol Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	
DIVISI ai or Atten s efter deal f Director: d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, larm, street, la	actory, office	28f. Location (Stree City or Town,	et and Number or Aural Route Number, State)
DIVISION OF VITAL HE TO THE HOSPITAL HE WITHIN 24 hours eiter death. To the Funered Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifier 12 Certifying Physical Control only 2 Medical Exemition	sician: To the best of my kno- ner: On the basis of examinal and manner stated.	wledge, death occu tion and/or investig	irred at the time, date and plac ation, in my opinion, death occ	e, and due to the causured at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To the within 2 To the complete	Me	29b. Signature and title of certifier	mella	m.0°	29c. License number D 4141(2)		Date signed (Month, Day, Year)
ાન		30. Name and address of person who co	mpleted cause of death (Item	1 23a) (Type, Print)		ACTEUR DES	Post Parity and Parity
Sta Regist		31. Date filed (Month, Day, Year) DEC 0	7 2005	ture	carle	Walling Ma	RYLAND 21204

DHMH 17 Rev 1/2001

Registrar

**ORIGINAL** 

	•	State of Maryland / De State of Maryland / De State of Maryland / De State of Maryland / De State of Maryland / De Registrer	partment of Healt 05 tas Certificate of Dea	h and Me	ntal Hygi	ene g. p. () (	15 39415
Dhysia	ion	1. Decedent's Name (First, Middle, Last) Earl Owen Bielha	rt	2	. Date of Death Month	Day	3. Time of Death 7:20 PMM
Physic /Medi		· Deilhart, 2008	4b. City, Town, or Locat	tion of Dooth	12	4c. County	
Exami	ner	4a. Fecility Name (If not institution, give street and number)  308 Torner Road	Baltimore				imore
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	fay) If Under 1 Year If Un	nder 24 Hrs. 8	. Date of Birth		9 Birthplace (State or Foreign
Funeral Director		218 14 6035   1 <sup>x</sup> x <sup>M</sup> 2 <sup>-</sup> F   82   Yrs	s. Months Days Hou	Ja	(Month, Day 2010 22	1923	Toledo, Chio
pur *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location				10d. Inside City Limits
Manyla	tor	Maryland Baltimore Baltimor	e County				1 ☐ Yes 2 ☐ No
ith the Marylar or 28a-f show	lrec	10e. Street and Number	10f. Zip Code		10	g. Citizen of	What Country?
th with	alD	308 Torner Road	21221			USA	A do to-di
er dea	Funeral Director	Armed Forces?	<ol> <li>Was Decedent of Hispania If Yes, specify Cuban, Mer</li> </ol>	c Origin? (Speci xican, Puerto Ri	ty Yes or No- can, etc.)		ce - American Indian, ck, White, etc.
irs aft	by F	1 □ Never Married 2 □ XMarried   1 □ XYes 2 □ No   If Yes, Give   3 □ Widowed 4 □ Divorced   Year or Dates: ₩₩ ∏	1 ☐ Yes 2 🙀 No Spe	ecity:		Specii	<sup>y:</sup> White
2 hou		(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during	most of working	, 1	6b. Kind of B	Business/Industry
ithin 7 ner nen "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	ife. DO NOT use retired)			IK Doat	al Service
lled w dygier ther th		12 1 Lett	er Carrier	Mother's Name (			
at y failed A LA 12-00000 should be filed within 72 hours atter death with the Maryland nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-1 show umatic event, the Medical Examinatings be inclified at	To Be	Farl Beilhart	Est	telline O	wen		
shoul mark	-	19a. Informant's Name/Relationship (Type, Print) 19b. M	Mailing Address (Street and N				, State, Zip Code)
, IVI			Torner Road Balt	-	-		City of Town State
DESIGNATION CE, INICITY ICIDIA 2 LA 13-0030 permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be indified at once.		cemetery,	Disposition (Name of crematory or other place)	Da			- City or Town, State e, Maryland
Daltimor  Dermit. Pages Department of mportant: If It any injury or o		Table 1	Luth Ch Cem. Dec		2005	MILLIIDE	e, racytaid
Day Departing Impoor		21. Stature of Funeral Service Licensee	22. Name and Address of F Lassahn Funeral 7401 Belair Roa		oro Mora	n and 21	236
		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, suc	ch as cardiac or	respiratory arre	est,	Approximate Interval Between
Pnysician		Immediate Cause (Final disease or condition	heart Pai	ilure			Onset and Death
/Medica		Immediate Cause (Final disease or condition resulting in death)  a	110	2012 111			
Examine		Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of	1171019 118	en se			
ted	nlner	Cause (Disease or injury	,				
<b>6U,</b> be executed icien and burial-transit	Examin	that initiated events c. Due to (or as a consequence of	):				
<b>68 / 60,</b> ificate be executed g physicien and as the burial-transit	icai	d					
. BOX 68 / death certificate e attending phys d for use as the	Med	IF FEMALE: 230 If you guttome of programmy				224 D	ate of delivery
BOX 6: leath certific attending p	Physician/Med	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)				Ionth Day Year
dS, P.O. Ruires that the deresigned by the a	ysk	1 Yes 2 No 9 Unknown					
Records, P.O. The law requires that the tab been signed by the bage 2 should be detached.	by Pl	Part II. Other significent conditions contributing to death but not resulting in	the underlying cause given in	Part I.			ntribute to the cause of death?
cords w require been sig					1 🗆 Ye	s 2 No	3ZProbably 4 □Unknown
Records, le law requires t has been signe ge 2 should be	Completed				24a. Was a autops perform	y	. Were autopsy lindings available prior to completion of cause of death?
	Corr				1 ☐ Yes	No	1 ☐ Yes ≥ No
of Vital Re Physician: The rithis certificate ha	Be	25. Was case referred to medical examiner?  Hospital:	Other	Place of Death	11.00		ther (Specify)
O E = E	. To	27. Manner of Death 28a. Date of Injury 28b. Ti	me of 28c. Injury at	_	8d. Describe ho		
ision ttending death. ctor: Afte	atlor	1 Natural 5 ☐ Pending (Month, Day Year) In 2 ☐ Accident investigation	jury Work? M 1 ☐ Yes	2 🗆 No			
Division of tor Attending Phy after death. Director: After this in by the funeral d	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	2	81. Location (St City or Town	reet and Nun n, State)	nber or Rural Route Number,
Dital ours aft		29a. Certifier 12 Certifying Physician: To the best of my knowledge.	death convenient the time d	ate and place a	nd due to the c	auco(c) and r	nanner as stated
Hosp 24 hou Fune stely fi	edical	29a. Certifier 1/2 Certifying Physician: To the best of my knowledge, (Check only one) and manner stated.	Vor investigation, in my opinior	n, death occurre	d at the time, d	ate and place	e, and due to the cause(s)
Division of To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral	Med	10h Signature and title of certifier	29c. License nur				ned (Month, Day, Year)
- sho		> Shelden Milren, Ms	10185	78		12/5	5/00
100		30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)		, ,	210	377
10		MID ALL I I I I I I I I I I I I I I I I I I	Pholadelp	enia le	ad	215	31/
Regi	State strar	DEC 0 7 2005	Type, Print)  O Phyladely				

			For Stata	riease				/ Depa		t of H	ealth a	and M	fental Hy		0.05	. ,	391.16		
			Registrar  1. Decedent's Name (Fin	st, Middle, La	st)				inout	0, 1	- Catri		2. Date of De		.000		3. Time of Death		
	Physici		Timothy J	nganh	Rargo	r							Month 12	05		ear 05	7:23 AM M		
	/Medic Examin		4a. Facility Name (If not						4b. City,	Town, or	Location o	of Death	12_		. County of		1.23 AM		
	Exquini		9313 Seve	n Cour	ts Dri	i ve			Bal	timo	re				Balt	imor	re		
- J.	Funeral		5. Social Security Number	er 6. 9	Sex	7. Age	(In yrs. las	st birthday)			If Under Hours	24 Hrs. Min.	8. Date of Bi (Month, D.	rth			lace (State or Foreign try)		
п	Director		213-60-441	3	<b>∑</b> M 2□	F	54	Yrs.	Wioritis	Days	110013	WIIIT.	02/27/	/1951 Maryland					
	pu &		Usual Residence of Deci	. County			10c City	Town or Lo	cation						10d. Inside City Limits				
	sho	5											10d. Inside City Lir 1 ☐ Yes 2 [5]						
	with the Maryland & or 28e-f show	ect	MD 10e, Street and Number	Baltim	ore		Ba.	ltimo	re 10f. Zip	Code				100 Ci	tizen of Wha	t Coup			
	with with				L D											it Coun	uyr		
	ours after death with the Marylan rel', or Items 23s or 28e-f show Examber motified at	Funeral Director	9313 Seve	n Cour	12. Was [	Decedent E	ver in U.S.	13.		236 dent of Hi	spanic Ori	gin? (Sp	ecify Yes or No Rican, etc.)		14. Race -	America	an Indian,		
(0	r Iter	Fur	1 Never Married	2 XMarried		d Forces? es 2 <b>X</b> No , Give	0					i, Puerto	Rican, etc.)		Black, \				
93	hours after turel', or Ite	b	3 ☐ Widowed 4 ☐	Divorced	If Yes Year	, Give or Dates:			1 ☐ Yes :	2X No	Specify:				Specify:	Wh	ite		
21215-0036	C1 00 LM	Completed		Decedent's E		ed)		16a. Dece	dent's Usua kind of wor	il Occupa rk done d	tion uring mos	t of work	ina	16b. K	(ind of Busin	ess/Ind	lustry		
21	within ane. then "	mpi	Elementary/Secondary			ge (1-4or 5-	<b>+</b> )		kind of wor DO NOT us		)								
2	be filed within 7. Ital Hygiene. It other then "n event, tre Med		12 17. Father's Name (First,	Middle Last	4			Auc	tione	er	10 Matha	ula Nasa	. /Circh Mintella		tion .	Indu	ıstry		
anc	ntal H ed of	Be											e (First, Middle		i Sumame)				
Ž	2 should be and Mental Is marked (reumatic ev	2	George Fr  19a. Informant's Name/F					10h Mailir	a Addrose	/Stroot a			na Rush al Route Numb		or Tour Sta	to Zin	Cadal		
Maryland	s 1 and 2 should f Health and Mer item 27 Is marke other treumatic																,		
ē,	ss 1 and of Health item 27 other tr		Karen G. 20a. Method of Disposition		(MII6	3)	20b. Plac	ce of Dispo	sition (Nan	ne of	1		ve - B		ocation - Cit				
JO	ages ant of nt: If it		1 ☐ Burial 2 🛛 Cre			om State			natory`or o			12/0	0/2005	De 14	L	3.6			
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral			<u>_</u>	Metr	O CFE	emator 1. Name an	<b>⁻</b> Y d Addres	s of Facilit	12/U	8/2005	Ball	Limore	- IVI	aryland Home, P.A.		
B	Depa Impo any ir		1 60 g	) X		0-1											and 21087		
	- *		23a. Part1. Enter the dis	ease, or com	plications th	at caused	the death.								e, na		Approximate		
	Physician		shock, or heart fail		one cause		LUN	C	ANC	M	de	TA	MAT	50			Interval Between Onset and Death		
	/Medical		disease or condition resulting in death)	-	a Due	to (or as a				1	17.6	1 /	,,,,			-	1 4/6		
٠	Examiner		Conventially list condition		b														
	p ≓	ner	Sequentially list condition if any, leading to immed cause. Enter Underlying Cause (Disease or injury)	iate	Due	to (or as a	consequer	nce of):											
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last		c														
760,	ite be executed iysician and ne burial-transit	Ē	resulting in death, cast		Due	to (or as a	consequer	nce of):											
687	0 % 0	dicai			d											-			
9 ×	leath certificat attending phy I for use as th	Physician/Med	IF FEMALE:		23c If ves	outcome o	of pregnanc	.v							001 0.11				
Вох	atten for u	cian	23b. Was decedent preg in the past 12 mont		1 🗆 Li	ve birth 2	2 Fetal de	eath 3	Ectopic pro						23d. Date of Month		Day Year		
o.	0 0 0	ıysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown			nknown		0	2 0 11 101 (ap			-							
<u>a</u>	requires that the een signed by th nould be detache	by Pł	Part II. Other significant	conditions	contributing (	to death bu	t not resulti	ing in the u	nderlying ca	ause give	n in Part I.		23e. Did	tobacco	use contribu	te to the	e cause of death?		
Records,	quire, n sig uld bi	q pe											1 🗆	Yes 2	5 3 E	] Proba	ably 4 Unknown		
၀	> 9 70	ojet											24a. Was		24b. Wer	e autop	sy findings available apletion of cause of		
R	9 L 9	Completed				*							auto perfe	psy ormed? 2 1 No	deat	r to com h? Yes			
Vital		Be C	25. Was case referred to	medical							26. Place	of Death	(Check only	1-	,		20,140		
<b>†</b>	S S S	To	examiner?		Hospital: 1	☐ Inpatien	nt 2 EF	VOutpatier	t 3 DO	A Othe	r: 4 □ Nu	rsing Ho	me 5 Resi	idence	6 Other (	Specify	)		
n of			27. Manner of Death 1 Natural 5 [	Pending	28a. D	ate of Injury Month, Day	Year) 21	8b. Time o Injury	2	8c. Injury Work	at ?		28d. Describe	how inju	ry occurred				
sio	Attending r death. ector: After by the fune	catl	2 Accident	investigatio					М		'es 2 🗆 i								
Division	or At fler d Sirect in by	Certification:	4 Homicide	determined	1 28e. P	lace of Injui uilding, etc.	ry - At hom. . (Specify)	e, farm, str	eet, factory	, office			28f. Location ( City or To			r Rurai	Route Number,		
	pitel ours a erel [	Ce	29a. Certifier 1	Fastificina Di	weicien, Ta	the best of	f mu knowle	odao dost	a annum d	at the tim	o dato on	d place	and due to the		) d				
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edicai	(Check only 2 one)	Medical Exa	ninar: On th	ne basis of a	examinatio	n and/or in	vestigation,	in my op	inion, dea	th occurr	ed at the time,	date and	d place, and	due to	the cause(s)		
	o the	Me	29b. Signature and title	of certifier						. License				29d. Da	te signed (N	1onth. D	Pay, Year)		
	FSFO		1 Co C	1						DZ	773	30		1	2/11	05	Phys.		
1	10		30. Name and address of	f person who	completed o	cause of de	ath (I <u>te</u> m 2	3a) (Type,	Print)					1	- /	4			
C	)		6 Aly	ouch	no	61	75	1-	C44	RUS	IT.		Stay	12/1	I P	クク	21204		
	Sta	4	31. Date filed (Month, Da	ay, Year)	3	2. Pegistra	r's Signatur	re		,							21204		
ă.	Registr	ar	DE	C072	2005	BOUN	w B	7. A	75451										

TIMOTAY BARGER

		1 - For State Registrar	State of Mai	•	artment of H rtificate of I		Re	eg. No.	) 5	39417
Physici	an	Decedent's Name (First, Middle, Last)	M	BRAD	S II A W		2. Date of Deat	-	2005	3. Time of Death 6:30 P M
/Medic		VIRGINIA	M -	DKAD		Location of Death	December	4c. County		0.30 F W
Examir	ier	4a. Facility Name (If not institution, give			· ·	isfield	!	40. County		erset
E		McCready Memorial 5. Social Security Number 6. Sec		(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Vasal	9. Birthp	place (State or Foreign
Funeral Director			M 2 <b>X</b> )F	87 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, July 12	, °°1918	Mar	yland
<u> </u>		Usual Residence of Decedent		10c. City, Town or Lo						10d, Inside City Limits
show	_	10a. State 10b. County		Toc. City, Town or La		61 3 3				1 XYes 2 No
Ba-1	ectc	Maryland Somer  10e, Street and Number	set		Cris 10f. Zip Code	field	1	Og. Citizen of	What Cou	ntry?
with t	ō				101. 2.p 0000	21817		<b>.</b>	USA	•
leath	<b>Funeral Director</b>	201 Hall Highway	12. Was Decedent Ev	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba		pecify Yes or No-		e - Americ	can Indian,
2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene.  Is marked other than "natural", or items 23e or 28e-f show aumatic event. The Marical Examiner must be mailfed.	by Fun	1 □ Never Married 2 □ Married	Armed Forces? 1 ☐ Yes ②∭No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	o Hican, etc.)	Specif	ck, White, 'y:	white
hour	edk	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kind of B	usiness/In	dustry
n ne	piet	(Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+	life.	kind of work done of DO NOT use retired	during most of wor d)	king			
d with giene er tha	Completed	9		<u></u>	Co-owne			Retai		afood
al Hy d othe	Be (	17. Father's Name (First, Middle, Last)					ne (First, Middle, i	Maiden Suman	ne)	
ould b Ment Ment arked	2	Arthur Marshall				Edith	-	City or Town	Ctata 7	- Codel
12 sh and 7 Is m		19a. Informant's Name/Relationship (T) Ralph T. Marshall			ng Address (Street) anal Driv					
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, If a Musical once.		20a. Method of Disposition	(DEGETICE)	20b. Place of Disp	osition (Name of	The state of the s	reconstruction and the second	20c. Location		
bermit. Pages Department of mportant: If it iny injury or o		1 🔀 Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	Sunnyridae	matory or other place Memorial Day	· · · · · · · · · · · · · · · · · · ·	1. 2005	Crisfia	.hle	Maryland
nit. P artme ortan injur.		21. Signature of Funeral Service License	Be Volus		2. Name and Addre				.107	rial j Idrid
Depariment of the sany in conce.		Mary Beth Bra	Celyou-Prui		06 W. Mai				7land	21817
Certificate be executed  Contilicate be executed by execu	icai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ifficury that initiated events resulting in death) Last	b. Due to (or as a	consequence of):  consequence of):	N.B				ON	Onset and Death
death certific e attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	23c. If yes, outcome c 1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 ☐ Fetal death 3	□Ectopic pregnanc □ Other (specify)	у		M	ate of deliv onth	Day Year
n se red	b	Part II. Other significant conditions of	ntributing to death bu	t not resulting in the	underlying cause giv	ven in Part I.		bacco use con es 2□No	tribute to t 3 ☐ Pro	the cause of death? bably 4 Junknown
The The te h age	Completed						24a. Was a autop perfor	sy	prior to co death?	opsy findings available ompletion of cause of 2 No
vician: Th ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only or	ne)		
_ × × × × × × × × × × × × × × × × × × ×	10	1 ☐ Yes 2 X No	Hospital: 1 Inpatier		ent 3 DOA		lome 5 ☐ Resid			ify)
afte and	ation:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28b. Time Injury	Wo	ryat rk? ]Yes 2 □ No	28d. Describe h	ow injury occu	rrea	
LIVISION  I or Attending after death.  Director: After din by the functions	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ry - At home, farm, s . (Specify)	treet, factory, office		28f. Location (S City or Tow		ber or Rui	ral Route Number,
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medicai C	29a. Certifier Check only one) Certifying Phr	ysician: To the best of iner: On the basis of and manner sta	examination and/or i	th occurred at the ti	ime, date and place opinion, death occu	e, and due to the durred at the time, d	cause(s) and m date and place	anner as , and due	stated. to the cause(s)
o the o the omple	Mec	29b. Signature and title of certifier	and marrier sta		29c. Licens	se number		29d. Date sign	ed (Month	, Day, Year)
F 3 F 8	1	16 ///Mh -	MO		D	39813	3	Decen	nber	5, 2005
1/		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	Do e.	Course	CR18	Geld	mo	718117
s	tate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	A. M. D		) -, -, -,		11.6	5, 2005 21817
Regis	trar	מרכוני	2005	aura Si	ANDERSON					

DHMH 17 Rev 1/2001

Registrar

DEC 0 7 2005

			1 - For State Registrar	State of Maryla	nd / Depa	artment of H	lealth and N		giene 0 0 5	39419
			1. Decedent's Name (First, Middle, Las	7)				2. Date of Dea		3. Time of Death
	Physici /Medio		Eileen C. Barra	clough				Decembe	er 4, 2005	2:00P M
	Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of Dea	ith
			Friends Nursing			Sandy S		<u>-</u>	Montgome	ry
	Funeral		5. Social Security Number 6. Se	7 M 2 X E	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bi	thplace (State or Foreign ountry)
	Director	ļ	215–50–7868 Usual Residence of Decedent	8.	3 Yrs.			Sept. 3	, 1922 Eng	gland
	land		10a. State 10b. County	10c. C	City, Town or Lo	ocation				10d. Inside City Limits
	Many -f sh	ţ	Maryland Montgome	rv Ro	ckville					1 ☐ Yes 2 No
	r 28a	jec	10e. Street and Number	110	CHVIIIC	10f. Zip Code		1	0g. Cîtîzen of What C	ountry?
	h with	Funeral Director	15220 Georgia Ave	nue		20853		I	United Sta	tes
	death	ner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp		14. Race - Am	erican Indian,
9	or the	正	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No		il res, specily cuba 1 ☐ Yes 21 <b>∑</b> No	Specify:	rican, etc.)	Black, Whi	te, etc.
9	be filed within 72 hours after death with the Maryland that Hyglene. So other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	d by	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates:		72 763 2/Q 110	opecny.		Specify: W	nite
<u>,</u>	nati	Completed	15. Decedent's Edi (Specify only highest grad	ucation de co <i>mpleted)</i>	16a. Dece	dent's Usual Occupa kind of work done o DO NOT use retired	ation during most of work	king	16b. Kind of Business	Andustry
2	withir ane. Ithan	du	Elementary/Secondary (0-12)	College (1-4or 5+)		ocial Worl			Numaina U	am o
2 2	Hygie ther ther		17. Father's Name (First, Middle, Last)		1 50	ocial work		e (First Middle I	Nursing H	onie
au	d be antal ted o	o Be	William Alexand	er Pincombe				iffiths	valour barraine)	
Maryland 21215-0036	should be fand Mental 1 s marked of umatic eve	2	19a. Informant's Name/Relationship (T		19b. Mailii	ng Address (Street a			City or Town, State,	Zip Code)
N N	permit. Pages 1 and 2 should be t Department of Health and Mental I Important: If item 27 is marked of any inlury or other traumatic even <u>once</u> .		Christopher T. S	tathes/Son					le, Maryla	,
altimore,	of Health aritem 27 is		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date	20c. Location - City or	
Ë	Pages nent of I nnt: If its ury or o		1 Burial 2 ☐ Cremation 3 ☐ 1 4 ☐ Donation 5 ☐ Other (Specify,		rklawn	natory or other place Memorial	Decen 2005	ber 8,	Rockville,	Maryland
alti	mit. I		21. Signatur Man ral Service Licens		Parl	2. Name and Addres	s of Facility Roh	ert A. I	Dumphrey Fi	meral Home/
ñ	Depa Impo any ii		1. Still	Server. MO	0803 R	ckville:	Inc. 30	0 West 1	Montgomery 2805	Avenue
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the dea						Approximate Interval Between
	Physician :		Immediate Cause (Final disease or condition	a Pneumonia						Onset and Death  1 Day
	/Medical		resulting in death)	Due to (or as a conse	quence of):					т рау
	Examiner		Sequentially list conditions	b Stroke						
	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cubacte or injury	Due to (or as a conse	quence of):					
	ecute and -trans	Examiner	that initiated events resulting in death) Last	C. Dua to (occasion						
8760,	sate be executed physician and the burial-transit			Due to (or as a conse	iquence or):					
687	law requires that the death centificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physiclan/Medical		d						
×	leath certifica attending ph I for use as th	/Me	IF FEMALE:	23c. If yes, outcome of pregi	nancy				23d. Date of de	livon
Вох	atter after u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
P.0.	that the dei led by the a detached f	ysi	1 □ Yes 2 🖾 No 9 □ Unknown	9□ Unknown						
<u>.</u> ت	res that igned b	by PI	Part II. Dther significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	the cause of death?
200	w require been sig should b							1 □ Ye	es 2□No 3□Pi	obably 4 🖔 Unknown
O O	s bee	plet						24a. Was a	24b. Were au	utopsy findings available completion of cause of
Vital Records,	The lav	Completed						autops perform	y prior to ned? death? !∑No 1 ☐ Yes	
ita	ysician: The is certilicate had director, page	ВеС	25. Was case referred to medical				26. Place of Deat			20110
<u>-</u>		To	examiner? 1 □ Yes 2 X No	fospital: 1 ☐ Inpatient 2 [	ER/Outpatien	t 3 DOA Othe	er: 4 Nursing Ho	me 5 🗆 Reside	nce 6 Other (Spe	cify)
0	tending Phi leath. tor: After thi the funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe ho		
Sio	tendi eath. or: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				res 2 □No			
Division of	I or Atten after deat Director: I in by the	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str ify)	eet, factory, office		28f. Location (Sti City or Town	reet and Number or Re , State)	ıral Route Number,
	urs a		On Continue to Continue Bi	of the Table 1			1			[.]
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medicel Exemi	sicien: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death nation and/or in	occurred at the time vestigation, in my op	e, date and place, pinion, death occur	and due to the ca red at the time, da	luse(s) and manner as ite and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	And marrier stated.		29c. License	number	29	d. Date signed (Mont.	h, Day, Year)
	- 3 - 5		Alinda 1	Vi Klin	/A 11 -	D 10/220	2.2	1	ecember 5,	
[[	0/1		30. Name and address of person who co	ompleted cause of death (Ite	om 23a) (Type	D4332	۷)	D	CCCIMDOL J,	
1			Abeda Khan, M.D.			·	olumbic	MD 210/	/,	
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature		wrumnrg,	13D 2104	4	
	Registr	ar	DEC 0 7	2005	K	Short a				

State of Maryland / Department of Health and Mental Hygiere 1

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	J	64	6-	

20832

Physician
/Medical
Examiner

**Funeral** Director

the Maryland item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avant. It a Madical Examiner must be notified at ould be filed within 72 hours after death with I Mental Hygiene. al Hygiene. and Mental permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 ts m any injury or other traum once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

The law requires that the death certificate be executed use as the burial-transit the attending physician and page 2 should be detached signed by has been this certificate Hospital or Attending Physician: funeral director, After

Diractor:

24 hours e

within 2

0

filled in by

completely

Division of Vital Records, P.O. Box 68760,

1 - For State Registrar Certificate of Death 1. Decedent's Name /First, Middle, Last) 2. Date of Death 3. Time of Death Month 2005 December 3:45P M Enola Verlander Bode 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1022 Windrush Lane Sandy Spring

If Under 1 Year | If Under 24 Hrs. |
Months Days Hours Min. Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F 578-62-1548 90 Yrs. Sept. 1915 Louisiana Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 Windrush Lane 20860 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) District of Columbia Elementary/Secondary (0-12) College (1-4or 5+) Teacher Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter C. Verlander Therese Lazarre ျှ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Bode/Daughter 1022 Windrush Lane, Sandy Spring, Maryland 20860 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cometery, crematory or other place)
Montgomery
Crematorium, Inc. 1 ☐ Burial 2 💆 Cremation 3 ☐ Removal from State December 11 1 4 ☐ Donation 5 ☐ Other (Specify) Prium, Inc. 2005

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 12005 21. Signature of Funeral Service Licensee Wisconsin Avenue M00803 23a. Part1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pneumonia resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Dementia Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 24 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) D23459 December 6, 2005

Registrar DHMH 17 Rev 1/2001

State

32. Recistrar's Signature

18109 Prince Philip Drive, #275, Olney, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Edward P. Taubman, M.D.

31. Date filed (Month,

			1 _ State	State of Maryland		artment of H			giene Reg. No.2 0 0 5	39421			
			Registrar  1. Decedent's Name (First, Middle, Last)			^ i		2. Date of Dea	ath	3. Time of Death			
	Physicia		Bobby			Chavi	5	Decemb	Day Year	5 230 PM			
7	/Medic Examin		4a. Facility Name (If not institution, give st The Johns Hopkin	1 1 1		4b. City, Town, or Bos Him			4c. County of Dea	th			
	Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day March 2	9. Bir 7 - 1954	thplace (State or Foreign ountry) NY			
			Usuel Residence of Decedent					1101111	.,				
	deeth with the Maryland me 23a or 28a-f ehow frivant be richtling at		10a. State 10b. County	10c. City	, Town or Lo	cation			10d. Inside City Limits 1 X Yes 2 □ No				
	Ba-f	cto	MD PRINCE G	EORGES L	ARGO	~~~~							
	ith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?			
	e 23a		501 HARRY S. TRU	MAN DRIVE  2. Was Decedent Ever in U.	C 13 1	20774 Was Decedent of Hi	enanie Origin? (S	pacify Vas or No.	USA 14. Race - Ami	encan Indian			
36	should be filed within 72 hours after deeth with the Marylan of Mental Hygiens. Trarked other than "natural", or Items 23a or 23a-f show marked other than "natural", or Items 23a or 23a-f show matte event, the Medical Examinar mail be inclified at	by Funerai	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	Armed Forces?  1 ☐ Yes 2 [X]No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 [X] No	n, Mexican, Puert	o Rican, etc.)	Black, Whi				
5-0036	2 hou	ted	15. Decedent's Educ		16a. Deced	dent's Usual Occupa	ation	rting	16b. Kind of Business	/Industry			
215	B. B. Wad	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	) )	King					
2	filed wil Hygien other th	Completed			SI	ECURITY				N REDSKINS			
Maryland 2121	be fill d oth	Be	17. Father's Name (First, Middle, Last)					ne <i>(First, Middl</i> e, NE SAMUE	Maiden Sumame)				
2	should be and Mental marked o	ပ္	BOBBY CHAVIS  19a. Informant's Name/Relationship (Type	a Print	19h Mailir	on Address (Street			or, City or Town, State,	Zin Code)			
N N	h ar		CYNTHIA HOWARD/WI						O, MD 2077				
altimore,	ss 1 and 2 of Health Itam 27 r other tr		20a. Method of Disposition	C	lace of Dispo	sition (Name of natory or other place	e)	Date	20c. Location - City or	Town, State			
Ĕ	Page ment annt: M		1  ⊕urial 2  Cremation 3  Re 4  Donation 5  Other (Specify)	KEN	SICO (	CEMETERY		12-2005	VALHALLA				
Balt	permit. Pages 1 and Depertment of Healt Important: If Itam 2 eny injury or other once.		21. Signature of Funeral Service License	morto		. Name and Addres $1701-31~{ m L}$			ORTON & SO	NS F.H., INC. 21217			
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death e cause on each line.	. Do not ent	er the mode of dyin	g, such as cardia	c or respiratory ar	rest,	Approximate Interval Between			
	Physician		Immediate Cause (Final disease or condition	Metastatic	- Lui	ng Cana	cer			5 moths			
	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):	)							
		ler	Sequentially list conditions, if any, leading to immediate	Due to (cr as a consequ	uarica of).								
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, 0,	cate be executed physicien and the burial-transit	I Ex	resulting in death) Last	Due to (or as a consequ	uence of):								
8760,	physic the p	dicai	d.	-									
Blox 6	n certific noing p u: e as	√Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna					23d. Date of de	elivery			
Ö.	that the death red by the atter detached for	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year			
P. O.	that the ed by th detach	Phy	9 Unknown  Part II. Other significant conditions confi		ulting in the u	adorhija a gayaa any	on in Dart I	23e Did to	obacco use contribute t	o the cause of death?			
rds,	w requires to been signe should be c		Partil. Other significant conditions con-	Thousand to depart but not rest	210119 111 0110 0	Tide Hylling Cause give	on are are a			robably 4 Unknown			
Division of Vital Records,	ysician: The law requires that the death certificate be executed is certificate hes been signed by the att. noing physicien and director, page 2 should be detached for use as the burial-transit	Completed						24a. Was autor perfo 1 ☐ Yes	an 24b. Were a prior to death?	utopsy findings available completion of cause of			
ta	lan: riffice	BeC	25. Was case referred to medical				26. Place of De	ath (Check only o					
>	w =		examiner? 1 Yes 2 No	ospital: 1 pmpatient 2	ER/Outpatier		4 Litturarily i	lome 5 ☐ Resid	dence 6 Other (Spe	ecify)			
D C	ing P	inol	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe	now injury occurred				
isio	Attend death ctor: ,	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, larm, str		Yes 2 □No	281. Location (S	Street and Number or F	Rural Route Number,			
Ö	urs efter red Dire	Certification; To	4   Nomicide	building, etc. (Specify	·) 			City or To					
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certificocompletely filled in by the funeral director.	edicai		ician: To the best of my kno er: On the basis of examina and manner stated.									
	with To t	Σ	29b. Signature and title of certifier			29c. Licens		0	29d. Date signed (Mon	/			
,	1 ^			el Munoz, MD		RES	) - 00		Vecember	6,2005			
E	7/2	-	30. Name and address of person who con Daniel Munut, 600			Print) imore Mi	0 2128	7					
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrat/s Signa			/ - 7.0	•					
	Regist		DEC 0 T	7 2005 Barrie	o St.	Goodse							

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year RUTH, CROWE II: IO AM DECEMBER 03 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL HARBOR BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 28F 72 Yrs. Director 213-30-2787 07/14/1933 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or then "natural", or Itama 23a or 28a-f show the Madical Examiner must be notified at Funeral Director MD Baltimore ¥es 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
anti filem 27 is merked other then "natural", or itema 23e or 1 urgent or other traumatic event, the Medical Engine must 1519 Marshall Street 21230 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 25 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Own Home College (1-4or 5+) Elementary/Secondary (0-12) Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward F. Young Ethel F. Bosley 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Ann Gore /daughter ,2900 Bristol Ct. Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages ' Depertment of H Important: If Ite any Injury or ot once. Dec 7 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Beltsville, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc. 2005 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licensee Litter MO 1443 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METASTATIC BREAST CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, EMPHYSEMA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗆 No of Vital 1 Yes 2 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) RESOOL Dood, MD DECEMBER 03, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANOVER ST., BALTIMORE, MD 21225 3001 SOOD S. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2005 Begun & Specker Registrar

		For State Registrar		ryland / Depa	<b>delible Ink.</b> artment of F <i>rtificate of</i> :	lealth and N	Mental Hygie	-	39423
Physic /Medi		1. Decedent's Name (First, Middle, Las Marie Catherine C	'oons				2. Date of Death Month 12	Day Year 04 2005	3. Time of Death  12:00 AM
Examin Funeral		4a. Facility Name (If not institution, give  Smith Care for t 5. Social Security Number 6. So	he Elderly	Z (In yrs. last birthday)	Edgewo	r Location of Death If Under 24 Hrs. Hours Min.	8. Date of Birth	4c. County of Dea  Harford  9. Bir	th thplace (State or Foreigountry)
Director		212-48-1008 Usual Residence of Decedent  10a. State 10b. County	□ M 2 💢 F	83 Yrs.			04/04/19		aryland  10d. Inside City Limits
n 72 hours after death with the Maryland "natural", or Itema 23a or 28e-f show adecal Exampter must be notified at	Director	MD Baltin  10e. Street and Number	nore	Baltimor			100	. Citizen of What C	1 ☐ Yes 2X No
with se or		6120 Fire P	_ 3		21220			II C A	100
fter death	Funerai	6120 Ebenezer Ro	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No	0		lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Ame Black, Whi	
hours after tural', or Ite	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: Wh	nite
be filed within 72 houtal Hygiene. Id other than "natural event, the Mac call	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	DO NOT use retired	during most of work	sing 16	b. Kind of Business	/Industry
filed v Hygie ther t		8		HO:	memaker_	10 Matheda Nem	o (First Middle Me	Own Hom	e
	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
2 should and Mer is marke aumatic	2	John Theodore Bo		19b. Maili	ng Address (Street		lizabeth l ral Route Number, C		Zip Code)
m 0 - b-		John A. Coons  20a. Method of Disposition  1 X Burial 2 Cremation 3 Companion 5 Other (Specify	Removal from State	20b. Place of Dispo	osition (Name of matory or other place	ce)		c. Location - City or	Town, State
d permit Pages  Department of Importent: If it is a my injury or once.		23a. Part1. Enter the disease, or comy shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying	plications that caused	the death. Do not en	1750 Bela	ir Road -	- Kingsvi or respiratory arres	lle, Mary	I Home, P. land 2108 Approximate Interval Between Onest and Death Nours Round
The law requires that the death certilicate be executed ate has been signed by the ettending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	c. Due to (or as a d. 23c. If yes, outcome c 1 Live birth 2 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 [	□Ectopic pregnanc;	,		23d. Date of de Month	livery Day Year
signed b	þ	Part II. Other significant conditions of	,	t not resulting in the c	0				o the cause of death?
sicien: The law requir certificate has been si irector, page 2 should I	Completed	Corona	y heart	disease	2		24a. Was an autopsy performe	prior to death?	utopsy findings availat completion of cause of
nysicien: iis certifica director,	Be	25. Was case referred to medical examiner?					th (Check only one)		
ding Phy I. After this funeral d	2	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatier  28a. Date of Injun (Month, Day)	y 28b. Time o	of 28c. Injui	y at	ome 5 Residence 28d. Describe how		Living for
To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not by determined	28e. Place of Inju	ry - At home, farm, st . <i>(Specify)</i>	reet, factory, office		28f. Location (Stree City or Town,	et and Number or R State)	ural Route Number,
To the Hospitel or within 24 hours afte To the Funerei Directory filled in the Completely filled in the completely filled	Medical	(Check only 2 Medical Examone)	ysician: To the best o niner: On the basis of and manner stat	examination and/or in	nvestigation, in my o	pinion, death occur	rred at the time, date	and place, and du	e to the cause(s)
With To t	Σ	29b. Signature and title of certifier	Sha	(4.6)	29c. Licens	se number	79	I. Date signed (Mon	n, MD 210
1/	1/	30. Name and address of person who	0.000	n, vn.w	U	-101	11 C	10 combe	23,200

State Registrar

State of Maryland / Department of Health and Mental Hygiene A 39426 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Year DOROTHY C. CARROLL 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MASONIC HOME OF MARYLAND COCKEYSVILLE BALTIMORE tf Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) 04/13/1910 (MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🔀 F 95 213-44-9946 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits or 28a-f show Examiner must be notified at BALTIMORE COCKEYSVILLE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 INTERNATIONAL CIRCLE 238 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2YRS Elementary/Secondary (0-12) SCHOOL TEACHER EDUCATION al Hygie other 1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be n and Mental I EDWIN B. CROMWELL DOROTHY THIERNAU 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA LANSINGER (DAUGHTER) 212 WALGROVE RD REISTERSTOWN, MD 21136. Health s 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 Burial 2 Ocremation 3 Removal from State
4 Donation 5 Other (Specify) GREEN MOUNT CREMATORY12/7/2005 BALTO CITY, MD. 21. Signature of Funeral Service Licensee. W. JENKINS & SONS YORK RD MONKTON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demete **Physician** /Medical Examiner Corebro Vascular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto for as a nonsequence of or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): O. Box 68760, by Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 DNo 23d. Date of delivery 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown δ Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🕱 No 24a. Was an has certificate 1 ☐ Yes 2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 ☐ Yes 2 XNo 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12-6-05 com leted cause of death (Item 23a) (Type, Print) lto, rul B 015 BANK ST LIBERTO KOBERT 31. Date filed (Month State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registre Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** December 3, 1409 2005 Dorothy Porlier Cell /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital 8. Date of Birth (Month, Day, Year)
Nov. 22, 19 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🏋 F Months Days Hours Min. 83 1922 New Jersey 119-22-6219 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b Counts 7 is marked other than "naturel" or Items 23s or 28e-f show traumatic event, the Maylosi Examinar must be notified at 1 ☐ Yes 21 No Directo Maryland | Montgomery <u>Bethesda</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5608 Jordan Road United States 20816 Funeral 14. Race - American Indian, Brack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Efementary/Secondary (0-12) Coflege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 end 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny lijury or other traumatic event 2008. Be Henry Porlier ၉ Bertrude Townley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles L. Cell / Son 301 South Pioneer Drive, Long Grove, Iowa 52756 20b. Place of Disposition (Name of cometery, crematory or other place)
Metropolitan
Crematorium 20c. Location - City or Town, State 20a. Method of Disposition December 6, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2005 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7537 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee 2 th M01353 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate fnterval Between Onset and Death Immediate Cause (Final Myocardia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Thu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated except.) Examiner attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes 2☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 P ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Naturaf 2 ☐ Accident 5 Pending

To the Hospital within 24 hours a To the Funeral I completely filled

DHMH 17 Rev 1/2001

State

Registrar

death.

after death

investigation

6 Could not be

3 ☐ Suicide

29a. Certifier

4 - Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

**ORIGINAL** 

1 ☐ Yes 2 ☐ No

12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

old Georgetown Rd Betheida MD. 20814

29d. Date signed (Month, Dey, Year)

05

М

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

8600

Enementy Physician

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

eonard

DEC 0 7 2005

		For State Registrar	State of	Marylan		artment of H		nd Mer		giene	005	39426
		1. Decedent's Name (First, Middle, La	ast)						Date of Dea	ath Day	Year	3. Time of Death
Physici /Medio	_	PHYLLIS HODSO	ON CUSTIS	3					EC O	_ ′	005	8:35 A M
Examir		4a. Facility Name (If not institution, gi	ve street and num	ber)		4b. City, Town, or	Location of D	Death		4c.	County of Dea	th
		NATIONAL NAVAI					HESDA	Her To				NTGOMERY
Funeral			Sex   7 1 □ M 2 🖾 F	7. Age ( <i>In yr</i> s. / 89	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8.	Date of Birt (Month, Da pr. 20	h Y. Year)	9. Bir 916 Ol	thplace (State or Foreign ountry)
Director		141-48-2774 Usual Residence of Decedent		09				A	pr. 20	J, 1	910 01	iio
/land		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
Man.	tor	Maryland Montgon	nery	Pote	omac							1 ☐ Yes 2 🙀 No
th tha	Funeral Directo	10e. Street and Number				10f. Zip Code				10g. Citi	zen of What C	ountry?
th will	ai	10402 Windsor Vi	ew Drive			20854				Unit	ed Sta	tes
r dea	ner	11. Marital Status	12. Was Deced	dent Ever in U. ces?	S. 13. \	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin n, Mexican, P	? (Specify Puerto Rica	Yes or No- an, etc.)		14. Race - Am Black, Whi	
s afte	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 If Yes, Give	,		I□Yes 2∏ No	Specify:			-	Specify:	
hours Turns		3 Widowed 4 Divorced	Year or Dat	tes:	162 Door	lent's Usual Occupa	ation			16h Kir	W of Business	hite
n 72	Completed	15. Decedent's E (Specify only highest gi	rade completed)		(Give	kind of work done of NOT use retired	ation du <i>ring m</i> ost of l)	f working		IOD. NI	nd or business	vindustry
d withingiene.	шо	Elementary/Secondary (0-12)	College (1-	4or 5+)		memaker	,			Ow	n Home	
Hyg other	Bec	17. Father's Name (First, Middle, Las	t)				18. Mother's	Name (Fi	irst, Middle,	Maiden	Sumame)	
ite, Intallyial to ZIZIO-0000 Is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-1 show other traumatic event, the Modical Examiner man be notified at	To B	Fred Hodson					Grac	e Sib	1ey			
VICITY 12 Short h and h 7 is ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (Street a	and Number o	or Rural Ro	oute Numbe	r, City or	Town, State,	Zip Code)
and 2 auth a alth a 27 i		Donald L. Custis	/Husband		10402	Windsor	View 1	Drive	, Pot	omac	, Mary	land 20854
of He		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 (	□Removal from S	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other plac 1 Nationa.	e) De	cembe	r	20c. Lo	cation - City or	Town, State
dillinor		`4 □Donation 5 □Other (Spec		Arı	Ceme	terv	12.3	. 200	)5	Arli	ngton,	Virginia ,
Dallillole, permit. Pagas 1 an Department of Heal Important: if item 2 any Injury or other		21. Signature of Emperal Service Lice	leur	. моов	303 Be	Name and Address thesda-Cl thesda, l	s of Facility hevy Cl Maryla	Rober hase, nd 2	Inc. 20814-	755 3501	hrey F 7 Wisc	uneral Home/ onsin Avenue
		23a. Part 1. Enter the disease, or cor shock, or heart failure. List on	nplications that ca	used the death	. Do not ent	er the mode of dying	g, such as ca	rdiac or re	spiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			ANULOC'	YTIC LEUK	EMIA					Onset and Death
/Medical		resulting in death)	Due to (c	or as a consequ	uence of):							
Examiner	Ļ	Sequentially list conditions.	b									
ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	or as a consequ	ience of):							
ou, ba exacuted ician and burial-transit	хап	that initiated events resulting in death) Last	c	or as a consequ	uence of):							
fou, e ba e: rsician e buria	a E											
OO/ ificate g phys	edicai	<u> </u>	d							-		
COIDS, F.O. DOX 00 000, w requires that the death certificate ba exacuted been signed by the attending physician and should be detached for use as the burial-transit	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc							2	3d. Date of de	livery
death death d for	Physician/M	in the past 12 months?	4□Pregna	rth 2 □ Fetal int at time of de		Ectopic pregnancy Other (specify)					Month	Day Year
by the	hys	9 ☐ Unknown	9□ Unknov	wn								
law requires that the as been signed by the submid be detached.	by P	Part II. Other significant conditions	contributing to dea	ath but not resu	ulting in the u	nderlying cause give	en in Part I.		23e. Did to	bacco u	se contribute t	o the cause of death?
aquire aquire an sig									1 🗆 Y	es 2X	DNo 3□P	robably 4 Unknown
faw requires as been sign	Completed								24a. Was		24b. Were a	utopsy findings available completion of cause of
The The ate ha	mo:								perfo	med? 2 XNo	death?	2 □ No
VICAL iclen: T certifical ector, p	Be (	25. Was case referred to medical examiner?					26. Place of	Death (C	heck only o	ne)		
OI VITA Physiclen: this certific ral director,	ဥ	1 ☐ Yes 2 XNo	1		ER/Outpatien		4 LI INUISII				Other (Spe	ecify)
ing P	on:	27. Manner of Death 1 XNatural 5 ☐ Pending	,	f Injury n, Day Year)	28b. Time of Injury	28c. Injury Work			Describe h	iow injury	occurred	:
Attending ar death.  ector: After by the functions	cat	2 Accident investigation 3 Suicide 6 Could not	be as Bi-		(-		Yes 2□No		1 /6	*******	4.4	
or Al	Certification:	4 Homicide determine	d 200. Place	g, etc. (Specify	me, rarm, str /)	eet, factory, office		201.	City or Tow		I Number of A	ural Route Number,
pours sours serei		29a. Certifying P	hvsician: To the I	best of my kno	wiedge, death	occurred at the tim	ne date and n	nlace and	due to the	cause(s)	and manner as	s stated
To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical	(Check only 2 Madical Exa	aminer: On the bas and manne	sis of examinal	tion and/or in	estigation, in my op	oinion, death	occurred a	at the time,	date and	place, and due	e to the cause(s)
To th Withir To th comp	×	29b. Signature and title of certifier		AA *	7	29c. License				29d. Date	signed (Moni	th, Day, Year)
		MILL	M	By	シ,	0101	235548	(VA)	)	DE	EC 2 20	05
10		30. Name and address of person who	completed cause	of death (Item	23a) (Type,						L CENT	ER
1		TIMOTHY M. QUAST		MC USI			ETHESD	A MD	20889	-560	00	
Sta		31. Date filed (Month, Day, Year)	32. Ae	egistrar's Signa	ture	all						
Regist	rair	DEC 0 7 2	1000	Correct of	1							

			1 - For State Registrar	State of M	1arylan	•			lealth a Death		ental H	ygien Reg. N		2 30	1. 5	27
	Dhuciai	a <b>n</b>	1. Decedent's Name (First, Middle,	Last)		-					2. Date of D Month	eath D	ay Ye	ear 3. Th	ne of De	eath
	Physici /Medic		Albert Charle								11	26	200	5 033	10	A M
	Examir	er	4a. Facility Name (If not institution,		r)				Location				County of I			
			Holy Cross Ho 5. Social Security Number		Age (In vrs. I	last birthday)		ver er 1 Year	Spri		8 Date of B		ontgo		ate or F	Poreign
	Funeral Director		220–12–3524	150 M 2□F	79	Yrs.	Months		Hours	Min.	8. Date of B (Month, ii Dec 5,	ay, Year		Birthplace (St Country) aryland	210 01 1	or ergiri
	ס		Usual Residence of Decedent						1		Jec 5,	172	J 1116			
	how	_	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Insid		
	Ba-f	cto		gomery	G.	arrett									Yes 2	XINO
	72 hours after death with the Maryland neturel; or itema 23a or 28e-f ehow ilical Evaninar must be notitled at	Funeral Director	10e. Street and Number				10f. Z	ip Code				10g. C	itizen of Wha	at Country?		
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	ter de	un.	11. Marital Status 1 □ Never Married 2 □ Marrie	Armed Forces	\$?	5. 13.	f Yes, sp	ecify Cuba	in, Mexicar	n, Puerto F	cify Yes or N Rican, etc.)	10-		White, etc.	n,	
336	ir, or	ρ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates	_		1 🗆 Yes	2 <b>∏</b> №	Specify:				Specify:	white		
21215-0036	2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Us	ual Occup	ation during mos			16b.	Kind of Busin	ess/Industry		unk
215	en "r	pie.	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	r 5+)	lite.	DO NOT	use retired	i)	COI WOIKII	ig					
21	ed wi	Completed	unk	unk			lands	scape								
nd	tal H d oth	Be	17. Father's Name (First, Middle, L.	·							(First, Midd					
γla	ould Men marke	မ	William J. Dov			Lander		(0)			zabeth			. To 0 41		11 10
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "neturel", or itema 23a or 28a-f ehow arry injury or other treumetic event, the Medical Evantment must be notified at ance.		19a. Informant's Name/Relationshi Margaret Dove/										rk, MI	ate, <i>Zip Code)</i> ) 2089	5	
	Healt		20a. Method of Disposition	010001	20b. P	lace of Dispo	sition (N	ame of	T		ate			y or Town, Sta	е	
ğ	nt of nt of t: if it		1 ☐ Burial 2 ☐ Cremation	3 Removal from Slat	e C	emetery, crei	matory`or	other plac	e)					,		
Baltimore,	artme ortan Injury		4 □ Donation 5 ☑ Other (Sp.			22	2. Name i	and Addres	ss of Facilit	tv		-				
Ba	Depa Impo		21. Sign ture of Funeral Service L	· Wade, M	ector		tate	Anat	omy B	oard		. Ва	ltimor	e Stree	et	
			23a. Pant. Enter the disease, or o	complications that caus	ed the death	h. Do not ent	er the mo	ode of dyin	MD g, such as	cardiac or	respiratory	arrest,		Approx	imate	
	Physician		shock, or heart failure. List o Immediate Cause (Final											Onset	Betwe	ath
4	/Medical		disease or condition resulting in death)	a	CHF is a consequ	uence of):								_		
н	Examiner		0	h												
	n =	ne	Sequentially fist conditions, if any, leading to immediate cause. Enjey Underlying	Due to (or a	is a consequ	uence of):										
	that the death certificate be executed ed by the attending physician and detached for use as the buriat-transit	edical Examiner	Cause (Disease or injury that initiated events	c												
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8760,	ate b	dica	`	d									_	-		-
9	ding p		IF FEMALE:	23c. If yes, outcon	se of pregna	incv						- 1	2010			
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live birth	2 Fetal	Ideath 3[	Ectopic Other (	pregnancy					23d. Date o Month		Yea	ar
P.O.	the d	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		54.11	_ Ott 10 (.									
	equires that the sen signed by th tould be detache		Part II. Other significant condition	s contributing to death	but not resu	ulting in the u	nderlying	cause give	en in Part I.		23e. Dio	tobacco	use contribu	ite to the cause	of dea	ith?
of Vital Records,	pures n sigr	Completed by	Diabetes								1 🗆	Yes :	2 <b>X</b> No 3[	Probably	l ∐Uni	known
Ö	> 0 %	jete	Peripher	al vascu	lar d	liseas	se				24a. Wa	s an	24b. Wei	re autopsy find	ngs ava	ailable
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tal	sicien: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	Check on	2⊠N one	0 10	Tes ZX NO		-
>	Physicien: r this certifica ral director, j	ToB	examiner? 1 ☐ Yes 2 🙀 No	Hospital:	tient 2🔀	ER/Outpatier	nt 3[][	Oth Oth	er: 4 □ Nu	rsing Hon	ne 5∐Re	sidence	6 ☐Other (	(Specify)		
0	ding Ph h. After th funeral	Ë	27. Manner of Death 1 ∑Natural 5 ☐ Pending	28a. Date of In (Month, I	jury Day Year)	28b. Time o	f	28c. Injun World	y at k?	2	8d. Describe	how in	ury occurred			
9	ending sath. or: After he funer	atic	2 ☐ Accident investiga	ation			М		Yes 2□	No						
Division	or Att	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	and 286. Place of	njury - At ho etc. (Specify		reet, lacto	ory, office		2		(Street a		or Rural Route	Numbe	er,
	spital o									- 2						
	5 년 년 19 년	edicai	29a. Certifier 1 Certifying (Check only 2 Medical E	Physician: To the be xaminer: On the basis and manner	of examina	wiedge, deat tion and/or in	n occurre vestigatio	d at the tin on, in my o	ne, date an pinion, dea	id place, a ith occurre	and due to the ad at the time	e cause( e, date ar	s) and manni nd place, and	er as stated. I due to the cau	ise(s)	
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and mainer	stated.		2	9c. Licensi	e number			29d. D	ate signed (A	Month, Day, Ye	ar)	
	E S F Ö			$\geq$	2	>		D005	3528	3		Nov	ember	29,	200	5
		1	Name and a ress of person w	ho completed cause o	f death (Item	n 23a) (Tv∷e.										
		`	Daphra A	inken	,	25	J	التميته	Lucia.	in	nd	20	878			
	St	ate	31. Date Med (Month, Day, Year)	7 2005 32. Ragi	strar's Signa	ture d	Carl	1	(	)						

		1	For Amend Item#1	State of Ma							-		_	meets.	39428	ļ
1 m			Decedent's Name (First, Middle, Last)								2. Date of De	eath			3. Time of Death	
747, 520	nysicia Medic		Dale Warren Ertv	vine, Sr.							12	Day	-	lear OSS	9.4001	A
7 77 75 75	xamin	er '	la. Facility Name (If not institution, give	street and number)	A	,	0		Location o	of Death		_	County of	Death		
*	4-0	5-	Flanklinsqua		PIT	2		sec	If Under	24 450			ait	M	ore	
	neral		5. Social Security Number 6. Sec. 214–96–0644	7. Age }M 2□F	(In yrs. Ia:	st birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of Bi (Month, Di May 1	ay, Year)		Count		In
	ector	-	Usual Residence of Decedent		10						May 1	2,190	)5  1	Mary	Tanu_	
yland	ta be	.	10a. State 10b. County		-	Town or Lo								10	d. Inside City Limit	
e Ma	notified	cto	Maryland Baltimon	re	N	Middle									1 Yes 2 XN	<b>5</b>
vith th	Feno	Director	10e. Street and Number				10f. Zip						izen of Wh	nat Coun	try?	
aath v	THE	-a	5 Nacelle Road	12. Was Decedent E	var in 11 S	13		1220	enanic Ori	gin? (Sne	cify Yes or N		S.A.	Americ	an Indian	
d 21215-0036 illed within 72 hours after death with the Maryland Hygiene.	Examiner rough by notified at	by Fur	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes ZXN If Yes, Give Year or Dates:			If Yes, spec	cify Cuba	Specify:	n, Puerto I	Rican, etc.)			White, e		
	lical	ted	15. Decedent's Edu (Specify only highest grade	cation a completed)		16a. Dece	dent's Usua kind of wo	al Occupa	ition Jurina mos	t of workir	na	16b. K	ind of Bus	iness/Ind	ustry	
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Maryland Maryland  Maryland  Maryland  Maryland  Maryland  Maryland  Mental Hy	B V B	m	17. Father's Name (First, Middle, Last)										Juniame,	,		
arylah should be	metic	၉	Samuel Frtwine, Ji 19a Informant's Name/Relationship (Ty Gale	C.		19b. Maili	na Address	(Street a			Bosle		or Town, S	tate, Zip	Code)	
and 2 s	rtreu	1	Gale T. Ertwine (1	Mother)			•				ore, Ma					
Baltimore,	Importent: it tem 27 is marked other than induces, any injury or other freumetic avant, the Madical Exagince.		20a. Method of Disposition  1 🖾 Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)		Cer	ace of Dispo metery, crea AIR M	osition (Nar matory or o	ne of ther place	9)	D	, 2005	20c. L	ocation - C	ity or To		
Baltir Permit. P	any injur	1	21. Signature of Pinese Service Licens	88	151,111	23	2. Name an	d Addres	s of Facilit	insk:	i Fune:	ral I	Home,	P.A		
7-4		4	23a. Part Enter the disease, or compl	ications that caused	the death.								ex, M	агут	and 21221 Approximate	_
	dical		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Retrofe Due to (or as a	crit	ON P.O.	1 50-1	CON	NO-W	ith	lung 1	M eto	stas	دٌ.	Interval Between Onset and Death	
Exan	niner	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	ı conseque	ence of):		_								
petno	and Il-transit	Examiner	Cause (Disease or injury that initiated events	3.												
9	buria		resulting in death) Last	Due to (or as a	ı conseque	ence of):										
ion of Vital Records, P.O. Box 687 and noting Physician: The law requires that the death certificate ath.	To the Funeral Director: After this sedifficate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the control	2 Fetal	death 3[	⊒Ectopic pi ⊒ Other (sp				W. T.		23d. Date Mont		ry Day Year	
T that	deta	y Ph	Part II. Other significant conditions co	ntributing to death bu	ıt not resul	ting in the u	ınderlying c	ause give	en in Part I		23e. Did	tobacco	use contrib	ute to th	e cause of death?	
rds quire	g pin	d be	fibcess covities	inleft	Abdon	MINOL	and P	4/11	1851	cal	1 🗆	Yes 2	□No 3	Prob	ably 4 Unknow	n
o w	2 sho	piet	50ft tissus								24a. Wa	s an	24b. W	ere autop	sy findings availab appletion of cause of	e
E a	ate ha	E	Bullous De	(mati	tik	<					peri 1 Yes	formed?	de	ath? Yes		
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of V	nis co	2	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatier		R/Outpatie			4 🗀 140		me 5 Res				)	
on C	Atter	ilon:	27. Manner of Death  1 ☐ Natural 5 ☐ Pending investigation	28a. Date of Injur (Month, Day	Year)	28b. Time o Injury	of M	28c. Injun Work	/at <br Yes 2□		28d. Describe	how inju	ry occurre	d		
Division of Vital Records, to Attanding Physician: The law requires to after death.	Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc							28f. Location City or To	(Street arown, State	nd Numbei a)	or Rura	l Route Number,	
Division  To the Hospital or Attendity within 24 hours after death	a Funeral letely filled	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best of ner: On the basis of and manner sta	examinati	vledge, deal on and/or in	th occurred ivestigation	at the tin	ne, date ar pinion, dea	nd place, a	and due to the ed at the time	e cause(s , date an	) and man d place, ar	ner as st nd due to	ated. the cause(s)	
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			For State	State of M	aryland						2001		
			Registrar			Cel	tificate of	Death		Reg.	No.CUU;	3. Time of Death	
	Physicia		1. Decedent's Name (First, Middle, I Catherine C								Day Year 200!		
	/Medic		4a. Facility Name (If not institution,				4b. City, Town,	or Location			4c. County of Dea		
	Examin	er	5000 Levino				В	altin	nore				
	Funeral			Sex 7. Ac	e (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under		ate of Birth fonth, Day, Ye	9. Bi	rthplace (State or Foreign country)	
	Director		215-01-3641	1□ M 🔏 🔀 F	86	Yrs.	Month's Days	Hours	Se	p. 27,	1919 M	aryland	
	₽		Usual Residence of Decedent  10a. State 10b. County		10c. City	. Town or Lo	cation					10d. Inside City Limits	
	laryla sho	ŏ	MD		1	ltimo						XIXYes 2 □ No	
	d within 72 hours after death with the Maryland plane. Jiene. Then "natural", or Items 23s or 28s-f show the "Mardical Examiner must be notified at the Mardical Examiner must be notified at	ect	10e. Street and Number		Du	TOTING	10f. Zip Code			Citizen of What C	Country?		
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	death ms 2	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.	Was Decedent of If Yes, specify Cu	Hispanic O	rigin? (Specify Y	(es or No-	14. Race - Am Black, Wh		
9	or Ite		XXNever Married 2 Married	1 ☐ Yes XXX	No		1 ☐ Yes <b>X</b> ☐XNo			,, •,	Specify:		
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b	事事	BeC	17. Father's Name (First, Middle, La	ist)				18. Moth	her's Name (Firs	t, Middle, Mai	den Sumame)		
<u>la</u> n	9 to 2 to 9	To B	George John	Eder				An	na Mar	y Nog	el		
Maryland 21215-0036	2 should and Men ie marke eumatic		19a. Informant's Name/Relationship	1 1							ity or Town, State,		
Σ.	s 1 and 2 should f Health and Mer item 27 is marks other treumatic		Carolyn Shaffe	r/Sister	oon n				Rd. Ba		re, MD		
ore	Pages 1 nent of H int: If ite	1	20a. Method of Disposition  XXBurial 2 Cremation 3	Removal from State			osition (Name of matory or other pi						
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Bal	permit. Pages Department of Important: If it any injury or o		21. Signature virtuellar sance Ci	Jum								Chapel P.A. 11s,MD21117	
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	Pnysician		Immediate Cause (Final disease or condition resulting in death)	_ a	elin	la	nler					17 mouth	
	/Medical Examiner		Due to (or as a consequence of):										
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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0	sician and burial-transit		resulting in death) Last	Due to (or as	s a consequ	uence of):							
8760,	ate be	dical	3	d									
89 x	ding p	/Med	IF FEMALE:	23c. If yes, outcome	e of pregna	ıncv					23d. Date of d	lelivery	
d.    Comparison of the content of t									Month				
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	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit		Part II. Other significant condition	and any and a second great and a			23e. Did tobad 1 ☐ Yes	tobacco use contribute to the cause of death?  Yes 2 XNo 3 DProbably 4 Dunknown					
oro	requi	Completed by	Allavissal	(40 ( 340	and Aro	5:0				<del></del>			
360	sicien: The law certificate has b irector, page 2 s	E E	- Mas mor an	Cartary	rayo	9.0				24a. Was an autopsy performe	prior to		
9	n: Th ficate or, pa	ပိ	25. Was case referred to medical					ac Dia			(No 1□Y	es 2 No	
₹	s cert	To Be	examiner?	Hospital:	Hospital: 1 ☐ Inpatient 2 ☐ E			Other			th  Check only one   ome 5 Residence 6 Other (Specify)		
10	g Physer this	Ë	27. Manner of Death	28a. Date of Injury 28						d. Describe how injury occurred			
io	auth. or: Afi	atio	1 Natural 5 Pending 2 Accident investiga	ation				Yes 2					
Division of Vital Records,	or Atter de Directo in by the	Certification:		Could not be determined 28e. Place of labeling, 6					Location (Street and Number or Rural Route Number, City or Town, State)				
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page	Medical C	(Check only 2 Medical E	Physician: To the bes xaminer: On the basis	of examina	wledge, dea tion and/or i	th occurred at the	time, date a	and place, and o eath occurred at	due to the caus t the time, date	se(s) and manner a and place, and d	as stated. ue to the cause(s)	
	o the vithin 2 o the omplet	Med	29b. Signature and title of certifier	and manner s	stated.		29c. Lice	ense numbe	r ~ 1 1	29d	. Date signed (Mo	- 0	
	r > F 0		1 / ording	· Nes	M. D	,	D	0054	4911		12-06	-2005	
-	3		30 Name and address of person v	the completed cause of	death (Item	n 23a) (Type	POEVE	ENE	AVE. Y	BAltin	WE MI	21215	
		ate	31. Date filed (Month, Day, Year)	2. Regis	trar's Signa	ature							
	Regist	rar	DEC 0 7 20	105	1	Spe	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - For State Registrer Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** December 1, 2005 1735 Richard A. Ericson, Jr. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthdav) **Funeral** 1፟M 2□ F Yrs. Hawaii 578-20-8681 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a, State f ehow Item 27 is marked other than "natural", or items 23a or 28e-f shot other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11304 Hounds Way United States 20852 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 □ No World If Yes, Give Year or Dates: War Ⅱ 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Maryland 21215-0036 Specify: ۾ 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Complet filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Foreign Service Officer Federal Government 2 should be filed w and Mental Hygier Is marked other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Coral Brown Richard A. Ericson, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 end 2 st of Health and Item 27 is n 25 Haviland Mill Road, Brookeville, Maryland Kristin E. Secan/Daughter 20833 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition December permit. Peges 1 Depertment of H Important: If Itel any Injury or oth 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 7, 2005 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850-2805 21. Signature The aral Service Licenses M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Yocardia nfarction Pnysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine been signed by the ettending physicien and should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 Z No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 R/Outpatient 1 Yes 2 No 3□ DOA ٩ 27. Manner of Seath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours e To the Funeral I completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of curtifier 29d. Date signed (Month, Day, Year) 05 D54776 Emergency Physician leted cause of death (tem 23a) (Type, Print) 8600 Old Georgetown Rd., Bethesda, Maryland 20814

State Registrar

DHMH 17 Rev 1/2001

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30. Name and address of person who comp

31. Date filed (Month, Day, Year)

32. Registrar's Signature

**ORIGINAL** 

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		-	For State Registrar	State of Maryland / Department of He  Certificate of D		ntal Hygiene	005 39431														
t	Physicia	an	1. Decedent's Name (First, Middle, Last		2.	Date of Death Month Day	3. Time of Death Year 0330 AM														
	/Medic Examin	er	4a Facility Name (If not institution, give	street and number) Hospital Bal	Location of Death	40.0	ounty of Death														
34	Funeral Director		5. Social Security Number  220-49-3964  15  Usual Residence of Decedent	7. Age (In urs. I st birthday) If Under 1 Year Months Days	Hours Min. 8.	Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)  Maryland														
	J within 72 hours after death with the Maryland jiene. Than "natural", or items 23s or 28s-f ehow Tra Medical Ezziri'rar must be notified at	ctor	10a. State 10b. County	Pasadona	<i>J</i>		10d. Inside City Limits 1 ☐ Yes 2 No														
		Funeral Director	10e. Street and Number 1052 Vena	Lane 211	22	L	en of What Country?  LSA  4. Race - American Indian,														
920	hours after de tural', or Items	þ	11. Marital Status  Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces 1. If Yes, specify Cuban, 1  Yes, Give Year or Dates:	spanic Origin? (Specific, Mexican, Puerto Ric	an, etc.)	Black, White, etc.														
1215-0036	within 72 ho ene. than "natur re Medicel I	Completed	15. Decedent's Edu (Specify only highest grad	(Give kind of work done du College (1-4or 5+)	uring most of working	16b. Kind	d of Business/Industry														
land 2	12 should be filed h and Mental Hyg 7 is marked othe traumatic event,	To Be Co	17. Father's Name (First, Middle, Last)  Amahl E. Fra		18. Mother's Name (F	First, Middle, Maiden S	Surname)														
, Maryland		T	19a. Informant's Name/Relationship (7) Amahl E. Fra	ype, Print)  19b. Mailing Address Street and 1052 Person	nd Number or Rural F	Paseder	4a, MD 2/122														
Baltimore	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or othar RDC8.		20a. Method of Disposition  1  Burial 2 Cremation 3  4  Donation 5  Other (Specify,	( TRENDOUNT ( PEX	watery 12	/12/05 Ba	ation city or Town, State														
Bal	permit. Par Departmen important: any injury		21. Signature of Funeral Service Licens  Luc U  23a Part 1 Foter the disease or common	lications that caused the death. Do not enter the mode of dying.	or Cacillis  Lock 7d  such as cardiac or r	ese tur. Bato.	MD 21212 Approximate														
	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Rulmonary Consolidat	ion		Interval Between Onset and Death 4 day														
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760,~		cal Examine	Cause (Disease or injury that initiated events resulting in death) Last	C																	
Box 687	# × 9		IF FEMALE: 23b. Was decedent pregnant	d. 23c. If yes, outcome of pregnancy	<u> </u>	23	3d. Date of delivery														
P.O. B	The law requires that the cate has been signed by the page 2 should be detached	hysicia	hysicia	hysicia	hysicia	hysicial	hysicia	Physician/Med	Physicia	Physicia	hysicia	hysicia	hysicia	hysicia	hysicia	hysicia	in the past 12 months? 1 □ Yes No 9 □ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			Month Day Year
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al Rec		Completed		r accident		24a. Was an autopsy performed?  1 Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 No														
Vital	Physician: this certificanal director,	o Be	25. Was case referred to medicat examiner?  1  Yes 2	Hospital: 1 patient 2 ER/Outpatient 3 DOA	26. Place of Death (in: 4 ☐ Nursing Home	5 Residence 6	□Other (Specify)														
ion of	ding h. After fune	Certification: T		28a. Date of Injury (Month, Day Year)  28b. Time of 28c. Injury Work'  M 1 T	28d. Describe how injury occurred																
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	with To t	Σ	29b. Signature and title of certifier	29c. License	number	29d. Date	signed (Month, Day, Year)														
•	A		30 Name and Alexand agrees who	completed cause of death (Item 23a) (Type, Print)	- 600	UKCE	mber 04, 2005														
	3		30. Name and address of person who o	600 N WOLFE ST. BA	LTIMORE	MD 213	287														
16	Sta Regist	ate rar	31. Date filed (Month, Day, Year) DEC 0 7 20	and manner stated.  29c. License  RES  completed cause of death (Item 23a) (Type, Print)  600 WOLFE ST.  BA  32 Registrar's Signature	,		•														

			1 - For State Registrar	State of		nd / Depa	artment of H	ealth a		ental Hyg	giene	305	39432
7	Physicia		1. Decedent's Name (First, Middle, Ruth		Fran	3_			+	2. Date of Dea Month	ath Day	200 4	
	/Medic Examin		4a. Facility Name (If not institution, s	NUYSI	nber)	one	4b. City, Town, or Bala	Location of	Death			County of Dealtimore	
· ·	Funeral Director		5. Social Security Number 215 09 6713		7 Age (In yrs. 92	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birtl (Month, Day JULY 15	1913	(	rthplace (State or Foreign Jountry) LIMOTE, Maryland
ore, maryla	Maryland -f ehow	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor	e		ity, Town or Lo							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with the 23e or 28a		10e. Street and Number 4505 Fullerton Aven	ue			10f. Zip Code 21236				10g. Citi USA	zen of What C	Country?
	be filed within 72 hours after death with the Marylan tall Hygiene. Id other than "natural", or tieme 23e or 28e-1 show event, the Madical Exeminer must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 M Widowed 4 Divorced	Armed Fo	2 [^]No ⁄e	1	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ※ No	ispanic Orig in, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify:	
	d within 72 ho giene. In then "natu	To Be Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1 N/A	-4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	during most	of workir			nd of Busines ekeeping	s/Industry -Own Home
	0 4 5 ×		17. Father's Name (First, Middle, La William Hurley	est)				18. Mother Olivia		(First, Middle, Mas	Maiden	Sumame)	
	ages 1 and 2 should but of Health and Ment t: if item 27 ie marked y or other traumatic e		19a. Informant's Name/Relationship John J Franz	o (Type, Print)			ng Address (Street a <b>Alden Road</b>			<sup>I Route Numbe</sup> Maryland			Zip Code)
	Pages 1 annount of He ment: if item ury or oth		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Specific Properties)		Canada	cemetery, cre	psition (Name of matory or other place em. December	° 5 200		ate		more, Mai	
Balt	permit. Page Department of important: if eny injury or		21. Signature of Funeral Service Li	oho Cho	nack	7	<sup>2. Name and Addres</sup> assahn Funet 401 Belair I	Road Ba	ltimo	re, Mary		21236	
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	ysicie iis certi directo	To Be	examiner?	Hospital: 1 🗆 1	Inpatient 2	ER/Outpatie	nt 3□ DOA Oth			(Check only o		6 □Other (Sp	ecify)
	ing P	edical Certification;	27. Manner of Death 1	(Mon.	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?					28d. Describe how injury occurred			
	i i i i i		3 Suicide 6 Could no determin	ad 286. Place	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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Die.	Physici /Medi	cal		EMANUEL	FOX					ber 4, 2		11:00 P
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	Director		216-40-1363 Usual Residence of Decedent	X 20 9	9 Yrs.					, 1906	Mary	land
	nryland how	_	10a. State 10b. County	10c. C	ity, Town or Lo	cation					1	10d. Inside City Limits
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36	72 hours after death with the Maryland naturel', or Reme 23a or 28a-1 ehow dical Exacilicat must be rodified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ∰ Widowed 4 ☐ Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WWT	ı	Vas Decede i Yes, specif	nt of Hispanic y Cuban, Mex	Origin? (Space)	pecify Yes or No Rican, etc.)	- 14. Race	- Americ c, White,	
21215-0036	hin 72 hou s. sn "nature Medical E	eted	15. Decedent's Ed	tucation	16a. Deced	lent's Usual	Occupation done during r	most of word	rine	16b. Kind of Bu		
121	within ene. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use	retired)					
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ylan	d ag b	ToB		Unknown					Unknow	ı		
Maryland	d 2 sho th and I 7 is mu traume		19a. Informant's Name/Relationship (							er, City or Town, S		
Baltimore,	Pages 1 and 2 should nent of Health and Me nt: If item 27 is merk iry or other traumatic		Gilbert A. Hoffma  20a. Method of Disposition  1 \overline{\Omega} \text{Burial} 2 \overline{\Omega} \text{cremation} 3 \overline{\Omega}  4 \overline{\Omega} \text{Donation} 5 \overline{\Omega} \text{Other} (Specify	Removal from State	Place of Dispo- cemetery, cren	sition (Name natory or oth	of er place)		Date	20c. Location - (	City or To	
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):							
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		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre	et, factory, o	iffice		28f. Location (S City or Tow	itreet and Number n, State)	or Rurai	Route Number,
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*	)		Shakunmala Gup	ta, M.D 96	50 SG	ntic	so Ra	oad	Suit	E110 C	olus	nhia
	Sta Registra		31. Date filed (Month, Day, Year)	32. Regiŝtrar's Signa	H A	well	0				21	045

	1	For State Registrar		Ce	rtificate	of D	Death		Reg. No	),	
Physicia /Medic	n	Decedent's Name (First, Middle, Las Audrey V	irginia		Howell			2. Date of De Month Decemb	Da	y 2005	3. Time of Death  15:32P
Examine	er	4a. Facility Name (If not institution, give 2809 1st Street 5. Social Security Number 6. S		(In yrs. last birthday,	Sparr	OWS	Point If Under 24 Hrs Hours Min	8. Date of Bi		Baltimor  9. Birth	
irector		220-38-9057  Usual Residence of Decedent  10a. State 10b. County	UM 204 F	63 Yrs.				May 6,	194		aryland  10d. Inside City Limit
8a-f eho	Director	MD Baltimo	re	Sparrov	vs Poir				10a Ci	tizen of What Co	1 ☐ Yes 2XIN
23a or 2	rai Dir	2809 1st Street				219	0:0:0:0	Sanati Van an N		USA 14. Race - Ame	
"natural', or itams 23a or 28a-f ehow olical Examinat must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 █️vorced	12. Was Decedent E Armed Forces? 1 Tes 2 No If Yes, Give Year or Dates:		If Yes, specif		Spanic Origin? (: n, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		Black, White	e, etc.
	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12 years	ducation de completed) College (1-4or 5	(Give	edent's Usual e kind of work DO NOT use	done di retired)	uring most of we	orking		on Home	ndustry
is marked other then aumatic event, tre M	To Be C	17. Father's Name (First, Middle, Last, William J. Schwin					_	me (First, Middle y G. Tar		n Sumame)	
7 is mari traumati		19a. Informant's Name/Relationship ( Joseph Rodenberg						Dundalk			lip Code)
int: If item 27 I		20a. Method of Disposition  1 Burial 2 Ocremation 3 4 Donation 5 Other (Specific	Removal from State	20b. Place of Disp	osition (Name ematory or oth	of er place	) Dec	Date cember 2005	20c. L	ocation - City or	Town, State
Important: Il eny injury o QDCE.		21. Signature of Fugeral Service Licer	. Con	necus	7110 Sc	olle	rs Poin	Home Of t Road,	Dunc	dalk,P.A dalk,MD.	21222
/sician ledical aminer		23a. Part 1. Enter the disease or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as)	Consequence of):	ni Ol	of dying	g, such as cardia	ac or respiratory a	Az	su	Approximate Interval Between Onset and Death
physician and s the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	С	a consequence of):							
y the attending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ H0 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pre □ Other (spe					23d. Date of del Month	ivery Day Year
s been signed t should be det	by	Part II. Other significant conditions of	contributing to death be	ut not resulting in the	underlying ca	use give	en in Part I.		_		the cause of death?
page 2	Completed								ormed?	death?	topsy findings availal completion of cause of
this certificate al director, paç	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ► No	Hospital:	nt 2 ER/Outpation	ent 3 DO	Othe	\c	eath Check only Home 5	/	6 □Other (Spe	cify)
After	Certification:	27. Manney of Death  1. Accident investigation  3 Suicide 6 Could not to determine determined.	De Place of Init	ury - At home, farm, s	М		rat k? Yes 2 ⊡No	28d. Describe	(Street a	and Number or Ri	ural Route Number,
within 24 hours after death.  To the Funerel Director: A completely filled in by the the	edical Cer	(Check only 2 Medical Exa	hysician: To the best	of ny knowledge de f examination and/or							
To the F	Med	29b. Signature and title of ediffier	and manner sta				number		١.	ate signed (Mont	n. Day, Year)  1 2005  2 12  1 MD
1			, ,				/ /	•	0	, 0	1000

			1 - For State Registrar	State of N	/laryland / D	epartme C <i>ertifica</i>			nd Mental Hy	giene	105	391.3	5
	Physic /Medi		Decedent's Name (First, Middle Cecelia Heinze	, Last)					2. Date of D Month Decemb	Day	Year 2005	3. Time of De 6:05 PM	
á	Examir		4a. Facility Name (If not institution Gilchrist Cente	r for Hospi	ce Care		Т	Location of C	Death	4c. C	ounty of Death		
4	Funeral Director		5. Social Security Number 215-54-3716 Usual Residence of Decedent	6. Sex 1 □ M 2 🖼 7. Å	kge (In yrs. last birth 57 Yı	Months	or 1 Year Days	Hours	Min. 8. Date of Bi (Month, D 11/28/	ay, Year)	9. Birth Cou MD	place (State or Finitry)	oreign
	e Maryland	ctor	10a. State 10b. County MD Baltin	ore	10c. City, Town						1	10d. Inside City L	
	with th	Director	10e. Street and Number	_			ip Code			10g. Citize	n of What Cou	ntry?	
	ne 234	Funerai	9622 Harford Roa	12. Was Deceden	t Ever in II S		234		2 (0		d State		
036	ours after d	þ	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	Armed Forces	3. 3.	If Yes, sp	_	, Mexican, P	? (Specify Yes or No Querto Rican, etc.)		. Race - Ameri Black, White, Dec <i>ify</i> : Whit	etc.	
0-6121	be filed within 72 hours after death with the Maryland stal Hygiene. Id other then "neturel", or Iteme 23a or 28a-f ehow event. It a Medical Exacidational be redified at	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-40)	r 5+)	ecedent's Usi Give kind of w ife. DO NOT	ork done du use retired)	ion iring most of	working		of Business/In		
Maryland 21215-0036	m - 0 =	Be	17. Father's Name (First, Middle, I	·	Pha:	rmacy (			Name (First, Middle	, Maiden Su	ітате)		
ary	and Me	7	19a. Informant's Name/Relationsh		19b. N	failing Addres			r Rural Route Numb	er, City or T	own, State, Zij	Code)	
o, ∑	1 and 2 Health am 27 I	1	Ernie Heinze, Sr., 20a. Method of Disposition	Husband				oad Pa	rkville,				
E E	Pages lent of H nt: If ite ry or of		1 Burial 2 Scremation 4 Donation 5 Other (Sp		20b. Place of D cemetery, Chesape	crematory or	other place)		Dec 5 2005		tion - City or To	own, State  Iaryland	
Baltimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic espage.		21. Signature of Funeral Service L	icensee	011112	22. Name a	nd Address ion an	of Facility d Fune:	ral Altern	atives		-	
9	Physician	ğ.	23a. Part1. Enter the disease, or shock, or heart failure. List of the disease or condition	only one cause on each	ed the death. Do not line.	enter the mo	de of dying,	asture such as car दे।प	s Drive B	altimo: rrest,	re, Mary	pland Approximate Interval Betwee Onset and Dear	
9/00,	Certificate be executed Carlo and Carlo as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a b. Due to (or a c.	s a consequence of) s a consequence of) s a consequence of)	:		410				YEUVS	
DOX O	death certif e attending id for use a	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		e of pregnancy 2   Fetal death at time of death	3 □Ectopic p 5 □ Other (s				23d	. Date of delive Month	ery Day Year	
ras, r	w requires that the de been signed by the should be detached	by	Part II. Other significant condition	ns contributing to death	but not resulting in th	e underlying	cause given	in Part I.		obacco use		ne cause of death	
	The lay ate has page 2	Completed							24a. Was autop perfo		prior to cor death?	psy findings avai npletion of cause 2 2 No	lable e of
N I I I	ysician: is certific director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	о П <b>Б</b> О (0)				Death Check only o			. (	
5	al d	$\vdash$	27. Manner of Death  1 Natural 5 Pending 2 Accident investigi				28c. Injury a Work?	4 □ Nursin	g Home 5 Resident Res			o Itaspice	
DIVISION	To the Hospitel or Attending is within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	and 286. Place of In	ijury - At home, farm tc. <i>(Specify)</i>	, street, factor	y, office		28f. Location (S City or Tox	Street and N vn. State)	umber or Rura	l Route Number,	
	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	edical (	29a. Certifier 1 Certifying one)	Physician: To the best kanninger: On the basis of and manner s	or examination and/o	eath occurred r investigation	at the time, i, in my opin	date and plain, death o	ace, and due to the courred at the time,	cause(s) and date and pla	d manner as st ce, and due to	ated. the cause(s)	
	To the comp	W	29b. Signature and title of certifier				c. License n				gned (Month, i		
1	1	/	Meron /2		7.0	1	00611	99			73, 200	5	
し	) /		30. Name and address of person w	6601	oeath (Item 23a) (Ty No∧Da CL	pe, Print) پر (وچ) کی م	LoTo	uson,	mo 21	204			
	Sta Registr		31. Date filed (Month, Day, Year)	DEC 0 7 200	Death (Item 23a) (Ty No ^ Do C G co. rar's Signature	J.	Goard						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death DECEMBER 5, 2005 **Physician** 4:20 FM BRENDA ROSETTE HINTON /Medical 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🛛 F YES Director 216-52-9714 54 <u>November 19,1951</u> MD Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD HARFORD ABINGDON Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 238 200 OAKLEAF CIRCLE 21009 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: Specify: Completed by 3 Widowed 4 Divorced BLACK "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 CLERK Harford Dept. of Health 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill ment of Health and Mental Hiant: If item 27 is marked other. CLYDE DAVIS LUCENDIA DAVIS ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELVIN L. HINTON SR./HUSBAND 200 OAKLEAF CIRCLE ABINGDON, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 12-10-05 BALTIMORE, MD 21. Signatur Funeral Service Licensee 22. Name and Address of Facility Wm. C. Brown Comm Harford P.A. 321 S. Philadelphia Blvd. Aberdeen, MD Part I. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIOGENIC SHOCK /Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner as the burial-transit or Attending Physician: The law requires that the death certificate be executed CORONARY ARTERY DISEASE Due to (or as a consequence of): Box 68760. ding physician VALVULAR HEART DISEASE Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) been signed by the a should be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? END STAGE RENAL DISEASE 1 ☐ Yes 2 X No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? DIABETES 24a. Was an autopsy performed? (es 2 No 1 Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After the funeral of 28a. Da of Injury (Month, Day Year) 27. Mariner of Death

1 A Natural

2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation To the Hospitel or Attsndin within 24 hours after death.
To the Funerel Director: Af completely filled in by the fur 1 Yes 2 No 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 12-5-05 MTRICLEM D 31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TNTHICUM M. D.

32 Registrar's Signature
7 2005 7691 OSLER DRIVE TOWSON, MARYLAND 21204 RICHARD 31. Date filed (Month, Day, Year) State DEC 0 7 2005 Registrar

			For Stata Registrar	State of Marylan		artment of He tificate of L			iene 005	39437
			Decedent's Name (First, Middle, Las	t)				2. Date of Deat	•	3. Time of Death
	Physici		Henry Heine					Month Novembo	Day Year r 28, 2005	
	/Medio Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea		4c. County of Death	3:35 PM <sup>™</sup>
	LXdiiii	ici	Ivy Hall Nursin				imore			
	Funeral		5. Social Security Number 6. Se		last birthday)		If Under 24 Hr	s. 8. Date of Birth	Baltimo	
	Director		218-09-5761	X M 2□F 84	Yrs.	Months Days	Hours Min	May 28,	Year) Cou	place (Stete or Foreign intry)
			Usual Residence of Decedent	04				May 20,	1921 Mary	yland
	ylan Mor		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mar.	ţo	MD Baltimon	re	Baltime	ore				1 ☐ Yes 2 ☐ No
	1 28 r	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Cou	intry?
	h wit	O E	1300 Windlass Dri	ive		212	20		USA	
	72 hours after death with the Maryland Insturet, or items 23s or 28s-f show dicel Examinational be inclified at	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. V	Vas Decedent of His	spanic Origin? (	Specify Yes or No-	14. Race - Amer	ican Indian,
9	or its	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		Yes, specify Cubar		rto Rican, etc.)	Black, White	
8	ours ours	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 22 Year or Dates:		☐ Yes 2∏ No	Specify:		Specify: W	hite
5-0036	72 hc	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Deced	ent's Usual Occupa	tion	unk	16b. Kind of Business/li	ndustry unk
2121	thin and a	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	kind of work done di OO NOT use retired)	uring most of we	Jiking		
7	filed within Hygiene. sther then "	no.		nk						
힏	oth vent	Be (	17. Father's Name (First, Middle, Last)			unk	18. Mother's Na	me (First, Middle, A	Maiden Surname)	unk
<u> </u>	ould be Mental arked o atic eve	To								
Maryland	E DEE		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailin	g Address (Street a	nd Number or F	iural Route Number,	City or Town, State, Zi	p Code)
	12 a		Ivy Hall Nursing	Facility	1300	Windlass	Drive R	altimore	MD 21220	
ē,	of Head		20a. Method of Disposition	1 6	face of Dispos	sition (Name of patery or other place			20c. Location - City or T	own, State
٤	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ∰ Other (Specify	nemoval from State	ometery, crem	iatory or other place	' i			
altimore,	permit. Pages Department of Importent: If It eny Injury or o		21. Sign wate of Furnaral Service Licens	see A	22	Name and Address	of Facility			
ñ	Dep Imp		21. Sign that of Funeral Service Licens Ronal L. S.	la le fige ector					Baltimore S	Street
			23a. Part1. Enter the disease or comp	licerons that caused the death	Ba Do not ente	ltimore,	MD 212	01	not .	Approximate
			shock, or heart failure. List only of Immediate Sause (Final	ne cause on each line.						
	Physician		disease or condition resulting in death)	a. Mogre	me	per	ne			
	/Medical Examiner			Due to (or as a Vonsequ	uence of):		,	0 0	on Dise	
		_	Sequentially list conditions,	b. Due to (or as a consequ	e l	158huc	live	Jupan	on Dise	en
	sit ed	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	uence ot):	5 1-		1+ 10		
	and I-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a consequ	me	Track	re h	who h	Sundih	
8/60,	de ey cien cien	Ë		Due to for as a consequ	uence or):					
×	icate be executed physicien and s the burial-transit	dicai	•	d						
D		•	IF FEMALE:							
X P	death certifi e ettending   id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1□Live birth 2□Fetal	I death 3 🗆	Ectopic pregnancy			23d. Date of deliv Month	•
	0 0 0	sic	1 Yes 2 No	4☐ Pregnant at time of de 9☐ Unknown	eath 5	Other (specify)			Month	Day Year
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<u>က်</u>	law requires that the de as been signed by the e 2 should be detached f	þ	Part II. Other significant conditions co	nthbuting to death but not resu	ulting in the ur	derlying cause giver	n in Part I.		acco use contribute to t	. /
ecords,	w requir been si should l	Completed	15 y Peru	svn		-		1 ☐ Ye	s 2 □No 3 □ Prol	pably 4 Unknown
ပ္ပိ	as be	pie	Degenen	Im Jr	nt	Discov		24a. Was ar	24b. Were auto	opsy findings available impletion of cause of
r	The law bete has	Ю	o <sub>.</sub>					perform	ed? death?	
VITA	ilcian: Th certificete rector, pag	Bec	25. Was case referred to medical				26. Place of De	ath (Check only one		
	g. 8. g.	To E	examiner? 1 Tes 2 100	Hospital:	ER/Outpatient	Othor	-		nce 6 Other (Special	(v)
_	on ō o □		27. Manner of Death	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Injury : Work?		28d. Describe ho		,,
<u>ō</u>	ath. r:Af	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Bay 7001)	injury		es 2 □No			
DIVISION	or Attending ifter death. Director: After in by the fune	Hic	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Str	eet and Number or Rura	al Route Number,
5	at or	Certification:	4 - Hornida	building, etc. (Specify	′)			City or Town,	, State)	
	hour hour nere y fills		29a. Certifier 1 Cartifying Phy	sician: To the best of my know	wledge, death	occurred at the time	, date and place	e, and due to the ca	use(s) and manner as s	tated.
	1 24 10 Fu	edicai	one) 2 Medical Exam	iner: On the basis of examinat and manner stated.	tion and/or inv	estigation, in my opi	nion, death occi	urred at the time, da	te and place, and due to	o the cause(s)
	To the Hospital or Attendin within 24 hours after death. To the Funerel Director: Aft completely filled in by the fun	M	29b. Signature and title-of certifier			29c. License	number	29	d. Date signed (Month,	Day, Year)
			) / Jaw		mi	) D 7	1464		11/29/0	5
			30. Name and address of person who c	ompleted cause of death /Item	23a) (Tuna 1	Print)	, , , ,		-11	
			Str Aliza	the km n	190	1 N - EUT	42 St	Carle 2	OK BALTIN	מאש שינים
le su	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sidge	1		14 26	2 MM 3	VO JUNE 1	21201
	Registr		DEC 0 7 2005	Blacker 15	Maria					

			1 - For State Registrar	State of Mar		/ Departn		ealth and		9	05	391,3	Q
	Physici	an	1. Decedent's Name (First, Middle, Las	Richard E	ngene	Hacker	r Cr		2. Date of De Month	Day	Year	3. Time of Death	-
	/Medic	al	4a. Facility Name (If not institution, give		agene			Location of Dear		4c. County	of Death	12:25 A	M
	Examin - Funeral Director	eı	Franklin Square 1 5. Social Security Number 6. Se	tospital Ci	in yrs. last	birthday) If U	Rosed		8. Date of Bin	BQ /	himor	ice (State or Forei y)	ign
	and w.		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, T	own or Location	1				100	d. Inside City Limit	ts
	r 28a-f eho	Director	Maryland Balti	more		10	of, Zip Code	Middle I	River	10g. Citizen of V		1 ☐ Yes 2 🖾 N	
	23a o	alD	1315 Washingtor	Irving La	ne			21220		United	Stat	es	
980	72 hours after death with the Maryland Insturel, or items 23s or 28s-1 ehow dical Examiner; out be ricitlish at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 및 Divorced	12. Was Decedent Ev Armed Forces? 15 Yes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Y	Decedent of His specify Cubar es 2 1	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	- 14. Rac	e - Americai k, White, et	n Indian,	
21215-0036	I within 72 ho lene. r then "netui I'le Maulcal	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de <i>completed)</i> Coltege (1-4or 5+)		6a. Decedent's (Give kind life. DO N		uring most of wo	rking	16b. Kind of Bu	isiness/Indu	stry	
		Com	8 Years	College (1-4015+)		Crar	e Oper	ator		Steel	Indu	stry	
Maryland	d la b	Be	17. Father's Name (First, Middle, Last)  Joseph Hacker						me (First, Middle,			1	
ary	d 2 should Ith and Meni	To	19a. Informant's Name/Relationship (7	ype, Print)	1.1	19b. Mailing Ad	dress (Street a		Funk ural Route Numbe	er, City or Town,	State, Zip C	ode)	
	1 and 2 Health a tem 27 is		Sandra L. Croy	(Daughter)		1864 Ch	urch Ro	oad Dur	ndalk, Ma	aryland	2122	2	
Baltimore,	Pages ent of nt: If it		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify		ceme	e of Disposition etery, crematory 1y Hill	y or other place	1	Date 2/9/2005	20c. Location -	,	n, State ⊇r, MD	
Ball	permit. F Depertm Importar any injui		21. Signature of Funeral Service Licens	Cand	2	Du 79	22 Wise	k Funera Ave.	l Home o	_Marylar	nd 21	222	
	Physician /Medical Examiner		23a. Pant Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a c	psi.	S	mode of dying	, such as cardía	c or respiratory ar	rrest,	1	Approximate nterval Between Onset and Death	
,	cate be executed oblysicion and the burial-transit	Examiner	Sequentially list conditions, Tary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Cua to (or an a c									
). Box 68760,	ath certifi ttending p or use as	Physician/Medical	in the past 12 months?	d.  23c. If yes, outcome of 1□Live birth 2: 4□Pregnant at tin 9□Unknown	Fetal de	ath 3 ☐Ecto	pic pregnancy er (specify)			23d. Date	e of delivery nth D	ay Year	
P.O.	s that the de ned by the a detached t	by Phy	9 ☐ Unknown  Part II. Other significant conditions co	entributing to death but	not resultin	g in the underly	ring cause give	n in Part I.	23e. Did to	obacco use contr	ibute to the	cause of death?	
ords	faw requires as been signe 2 should be		profound hypor	remia	<del> </del>				101	∕es 2□No	3 Probab	oly 4 Dunknow	'n
al Records,	The ate h page	Completed	CAD							rmed? d	Vere autops rior to comp leath? Yes 2	y findings availab pletion of cause of No	le
ξ		To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2   ED	Outpatient 3[	DOA Othe		ath <i>Check only</i> o	-			-
Division of Vital	Attending Physic death. ctor: After this by the funeral di		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	28	b. Time of Injury	28c. Injury Work	at	dome 5 Resid	now injury occurre			
Divis	7 2 2 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	· At home (Specify)	, farm, street, fa	actory, office		28f. Location (5 City or Ton	Street and Numbe vn. State)	er or Rural F	Route Number,	
	Hospital of 24 hours al	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of iner: On the basis of example and manner state	xamination	dge, death occu and/or investig	irred at the time ation, in my op	e, date and place inion, death occu	e, and due to the durred at the time,	cause(s) and mai date and place, a	nner as stat and due to th	ed. ne cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	2 ATTEN PHY	JDIN		29c. License	number 60997		29d. Date signed	(Month, De	ıy, Year)	
7	N	/	30. Name and address of person who o	ompleted cause of dea	th (Item 23	a) (Type, Print)			Baltin	14 00	100	727	
*	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's	o arginatar c	S. 1	square	Drive	Dalba	nore, M	1 61	01	

Hae Ker, Richard

			1 - For State Registrar	State of M	larylar				lealth a		lental Hy	giene Reg. N		5	394	40
			Decedent's Name (First, Middle, La	st)							2. Date of De		<u></u>		3. Time of	f Death
	Physici		Cheryl Ra	ae Hur	t						Month Decembe	er l	200	∕ear 5	3:20	0 A <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number	)		4b. City,	Town, or	Location (				. County of			
			Holy Cross Ho	spital				Sil	ver S	Sprin	g		Mont	gome	ery	
	Funeral		Social Security Number 6. S			last birthday)	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da August	th Vear		9. Birthp	place (State	or Foreign
п	Director		216-74-5376	□M 2⊠F	4	8 Yrs.	IVIOTITIS	Days	110013	1711111	August	3, 19	57 W	ashi	ngton,	, D.C.
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation								Od Incide C	Situa & London
	sho	ō			100.01	•									0d. Inside C	24∏ No
	the A	Director	Maryland Montgor  10e. Street and Number	iery		ROCE	cvi11					10- 0	tizen of Wh			
	within 72 hours after death with the Maryland ene. then "natural", or items 23a or 28e-f show the Madical Examiter man be notified at	ā	11222 Tray Road	İ			101. 21		20852	)			ted S		,	
	leath	by Funeral	11. Marital Status	12. Was Decedent	Ever in U	IS 13 1	Was Dece				activ Ves or No		14. Race			
<b>'</b>	ther of	F	1 ☐ Never Married 2 ☒ Married	Armed Forces 1 ☐ Yes 2 🛣	?		f Yes, spe	cify Cuba	n, Mexican	n, Puerto	ecify Yes or No Rican, etc.)			White,		
8	urs a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes	2 🔯 No	Specify:				Specify:	Whi	Lte	
Õ	72 ho	Completed	15. Decedent's E	ducation		16a. Dece	dent's Usu	al Occupa	ation	A = 4		16b. K	(ind of Busi	ness/In	dustry	
2	thin 7	ple	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	ise retired	during mos )	st of worki	ng					
2	ed wi	Son	12				Stat	isti	cian			Re	searc	h Ir	ndustr	У
<u>n</u>	d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle		Sumame,	)		
<u>y</u> la	ould Men arke	L <sub>o</sub>	Raymond H. Hurt								a Willa					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or items 23a or 28e-f show any injury or other traumatic event, the Mudical Examination into the notified at ance.		19a. Informant's Name/Relationship (				_				I Route Numb				,	
e,	1 and Health		Richard A. Woode	n/Husband		IIIZZZ Place of Dispo			d, Ro		ille, M		and 2			
چ	in in it		1 ⊠Burial 2 ☐ Cremation 3 ☐		Sec	iuatchie	na(974)9[8	other place	e) D	eceml	per 8,					
Baltimore,	rtmer rtant njury		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Lices		Men	orial G			F-allia	200	05   I	Kimb	all,	Ten	nessee	tomo/
Ba	Depa Depa Impo eny i		21. Signature of Funeral Service Lices	TEW.	MO13	386 RG	ckvi	11e,	Inc.	300	rt A. 1 West M 20850-2	lone	gomer	y Av	enue	.ome/
			23a. Part1. Enter the disease, or com	olications that cause											Approximat	
	Discontinuo		shock, or heart failure. List only Immediate Cause (Final	one cause on each	ine.							,,,,,,			Interval Bet Onset and I	tween
	Physician /Medical		disease or condition resulting in death)	a Metast			Cell	Lung	g Can	cer				-		
	Examiner					reatiti	G									
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as												=
	cuted nd ransit	Examiner	that initiated events	C												
ó	e exe ien ar irial-t		resulting in death) Last	Due to (or as	a conseq	uence of):										
8760,	icate be executed physicien and s the burial-transit	dlcal		d												
Õ	ing p	Med	IF FEMALE:					· · ·							-	
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3	Ectopic p						23d. Date (		,	Year
o i	at the de by the a tached f	/sic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown	t time of d	leath 5	Other (sp	oecrfy)					WOIT	•	Day	i oai
٥.	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	by Physiclan/Me	Part II. Other significant conditions of	ontributing to death I	out not res	ulting in the ur	nderlying	ause dive	n in Part I		23e. Did t	obacco i	ise contrib	ute to th	e cause of d	death?
Vital Records,	sign d be			•			,	g							ably 4 ∐t	
ò	w require been sig should b	Completed							•							
ě	The tay ate has page 2	ď									24a. Was autor		prio	ore autop or to cor ath?	osy findings npletion of c	available ause of
<u>a</u>			25. Was case referred to medical								1 ☐ Yes	2 <b>₹</b> No	1	Yes	2⊠ No	
	ysicien: is certific director,	To Be	examiner?	Hospital: 1X Inpati	ont 2	ER/Outpatien	t 3 DC	Othe			Check only o		• ma:	10 1		
<u></u>	Phy eral c		27. Manner of Death	28a. Date of Inju		28b. Time of		28c. Injury Work	at Nu		ne 5 🗆 Resid				"	
<u>0</u>	uttending I death. ctor: After y the funer	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		y rear/	Injury	М		? ′es 2 □ i	No						
Division of	er de er de recto by th	iffe	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of In	jury - At h	ome, farm, stre	eet, factor	y, office		2	28f. Location (S City or Tov	Street an	d Number	or Rura	i Route Num	iber,
ā	spitel o	Certification;		5559, 5							Ony or 101	WI, State	"			
	To the Hospitel or Attending Physicien: whith 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.		(Check only 2 Medical Exam	ysician: To the best niner: On the basis of	of my kno	wledge, death	occurred	at the tim	e, date and	d place, a	and due to the	cause(s)	and mann	er as st	ated.	3)
	To the Hos within 24 ho To the Fun completely	Medical	one)	and manner st	ated.											′
	7 × 0 0		29b. Signature and title of certifier	01				. License					te signed (i			
	12		- Mallalle	Xh				00625	20			ресе	mber	1,	ZUU5 	
0	-		30. Name and address of person who Marie D'Arbela, M	completed cause of a	Fore	n 23a) (Type, st. Glet	Print) 1 Roa	d. S	ilver	Snr	ing. Ma	rv1	and 2	0910	)	
	Sta	10	31. Date filed (Month, Day, Year)	32. Regist	×					. JPI			L		-	
	Registr			7 2005 ▶ &	-	. 45.54	ALCON.	1								

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2:00P. DEC. 02 2005 JONES DORIS /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE CALVERTON HEIGHTS AVENUE 2526 If Under 1 Year II Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🗙 F Yrs. JULY 9, MD Director 219-20-9578 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "naturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at 1 XYes 2 ☐ No BALTIMORE MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 USA 2526 CALVERTON HGHTS AVENUE 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ☐ No Specify: SpeciBLACK δ 3√ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Depertment of Health and Mental Hygient Important: if Item 27 Is marked other the eny injury or other traumatic event. ITE 1 006. AUDITOR U.S. GOVT. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) BEATRICE HENRY MELVIN SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2526 CALVERTON GHTS. AVE., BALTO., MD 21216 ROBERT HUMPHRIES, II/NEPHEW 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 12/9/05 BALTO., MD 4 ☐ Donation 5 ☐ Other (Specify) KING MEM. PARK 21 Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS STREET, BALTO., MD 21217 23a. Part. Enter the disease, or comprications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the attending physician and shed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only only No No Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type-Print)

HNURADHA REODH (\*D. 52) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland	-	nt of Health a		Hygiene	2005	39442
	Physici	an	1. Decedent's Name (First, Middle,				2. Date o Month		Year	3. Time of Death
	/Medic		GLORIA	nosyhot				MBER Z	2, 2005	0805 AM
}	Examin	er	4a. Facility Name (If not institution,			Town, or Location		4c. C	BALTIM	265
	Funeral		5. Social Security Number	S. Sex 7. Age (In yrs. las	st birthday) If Unde	r 1 Year If Under		f Birth		place (State or Foreign
	Funeral Director		214-26-4260	10 M 2XF 75	Yrs. Months	Days Hours	Min. 8. Date o	21193	Cou	MD
	pu a		Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location					10d. Inside City Limits
	Aaryla Febor	ō	1.1	1	A 1	11,				1 Yes 2 No
	28e-	rect	10e. Street and Number	PHOTE CO	Dings Mi	p Code		10g. Citize	en of What Cou	ntry?
	h with	D	4604 Waterta	11 Ct. Apt. 1		21117			1154	
	ems 2	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. Was Dece	dent of Hispanic Or	igin? (Specify Yes on, Puerto Rican, etc.		4. Race - Ameri Bfack, White,	
36	or It	by Fu	1 Never Married 2 Marrie	d 1 ☐ Yes 2 No If Yes, Give	1 ☐ Yes				Specify: 12	- 10
Ö	within 72 hours after death with the Maryland sne. than "naturat", or items 23s or 28e-f ehow he Medical Examiner must be notified at	ed b	3 ☐Widowed 4 ☐ Divorced  15. Decedent's	Year or Dates:	16a. Decedent's Usu	ual Occupation		16b King	d of Business/In	idustry
215-0036	n na n na Medis	plet	(Specify only highest Elementary/Semindary (0-12)		(Give kind of we	ork done durina mos	st of working	Lev	linda	Je,
212	giene grentha	Completed	2 Identificatly (0-12)	Collage (1-401 34)		PN		Ger	iatric	c Center
nd	be filed stal Hygis of other event,	Be	17. Father's Name (First, Middle,	ist)		18. Moth	er's Name (First, M	ddle, Maiden S	Sumame)	
<u> </u>	should ind Men marka umatic	ို	William H	All Trung frient	10h Maifer Addres	Company	zabetr	Ha	SKIN	3
Maryland	0 0 2 6		Flundad Tobas	n Husband	19b. Maifing Address	La Lili Ca	Act D	ALLIDAS	Mella	mball7
	s 1 and f Health item 27 other tr		20a. Method of Disposition	20b. Plac	ace of Disposition (Na metery, crematory or	me of	Date	20 Loc	ation - City or T	
E	Pages nent of int: If it iry or o		1 ABurial 2 □ Cremation : 4 □ Donation 5 □ Other (Sp.	Hemoval from State	mission fi	rest	12/9/05	- Ow	mas M:	Ils. MD
Baltimore,	permit. Page Depertment o Important: If eny injury or once.		21. Signature of Fureral Service		Yavamak	nd Adoress Cacilli	eene Fun	eral, S	elvice	3
	89 E 9 9		Youghn C.	priese	8728	Liberty R	d. Rand	allstou	n, mi	
				ompfications that caused the death. nly one cause on each line.	Do not enter the mo	de of dying, duch as	cardiac or respirato	ry arrest,		Approximate fnterval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		myorardis	1 infare	tion			days
	Examiner			Due to (or as a conseque		U				dura
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseque	ence/ot):	L				
	sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с						
,092	ite be exe iysician a ne burial-l		resulting in death) Last	Due to (or as a conseque	ence of):					
687	3 5 6	dlcal		d	- ,			-		
×	certif nding use es	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance				23	3d. Date of defiv	erv
ă	death e atte	icla	in the past 12 months? 1 ☐ Yes 2⊠ No	1 Live birth 2 Fetaf d					Month	Day Year
P.O. Box	The law requires thet the death certifica ete has been signed by the attending ph page 2 should be detached for use es it	by Physician/Med	9 ☐ Unknown	9□ Unknown						
	res the		Part II. Other significant condition	s contributing to death but not result	ting in the underlying	cause given in Part I				he cause of death?
0.00	requi	eted						•		bably 4 Núnknown
Rec	has b	Completed					a	Mas an lutopsy performed?	prior to co death?	ppsy findings available impfetion of cause of
Vital Records,	ificete or, pa		25. Was case referred to medical			26 Place		es 2000		2 N No
<u> </u>	ysicie is cert direct	To Be	examiner? 1 ☐ Yes 2 No	Hospital: 1 2 Inpatient 2 E	R/Outpatient 3 □ D	Othor	ursing Home 5 I F		Other (Special	(v)
0 4	ng Ph fter th meral		27. Manner of Death 1 ☑Natural 5 ☐ Pending	(Month Day Vane)	28b. Time of Injury	28c. Injury at Work?	28d. Descr	ibe how injury	occurred	
Sio	tsndi Jeath. tor: A the fu	catl	2 Accident investigation inve	ation	M	1 Tes 2		(0)		
Division of	atter of Direction by	Certification;	4 ☐ Homicide determin		ne, tarm, street, factor	ry, office		n (Street and Town, State)	Number of Hur	al Route Number,
_	To the Hospital or Attanding Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifying	Physician: To the best of my knowl	ledge, death occurred	at the time, date an	nd place, and due to	the cause(s) a	ind manner as s	stated.
	n 24 h	Medical	(Check only 2 Medical E	xaminer: On the basis of examinatio and manner stated.	on and/or investigation	n, in my opinion, dea	ath occurred at the ti	me, date and p	place, and due t	o the cause(s)
	To t To t	Σ	29b. Signature and title of certifier		29	c. License number			signed (Month,	
)	.1/	/	Chityon	mo		D0059	736	De	turba	2 2005
	M.		254	tho completed cause of death (ftem 2	23a) (Type, Print)	1403 PITE	5401	ULD E	OULT	ROAD
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		THE COME	3-701	- W		CHP
	Regist		DEC	7 2005 Keeper	16 Aco	<i>L</i> 2				
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DOMONI JONES 05-08160 RKD

									nd Mental Hyg		·
			for State Registrar	Olate	or marylari		rtificate of L			.g. N2. 0 0 5	39443
	Physici	an	1. Decedent's Name (First, M	iddle, Last)	_				2. Date of Dear		3. Time of Death
	/Medic		Punon	+101	1eS				DECEMBE	ER 3, 2005	6:50P. M
	Examir		4a. Facility Name (If not institu			מילוחינאי	4b. City, Town, or		Death	4c. County of D	eath
	Funeral		JOHNS HOPKINS 5. Social Security Number	6. Sex	7. Age (In yrs.	ENTER last birthday)	BALTIMOI If Under 1 Year	II Under 24		9.1	Birthplace (State or Foreign
ù	Director		220-80-5748		45	Yrs.	Months Days	Hours	Min. Month Day	-60 A	Larulan D
	and w		Usual Residence of Decedent 10a. State 10b. Cou		10c. Cit	ty, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	호	MD		R	c.14	more	_			1 ☐ Kes 2 ☐ No
	or 288	lrec	10e. Street and Number			$\omega_{l'l'l}$	10f. Zip Code		1	0g. Citizen of What	Country?
	death with the Maryland oms 23e or 28e-f show ir nust be notified at	a D	1 Gemic	i Cour	+		212	37		USA	
	ter de:	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ F	Amed	ecedent Ever in U. Forces? s 2 <b>X</b> lo	.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origir In, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
036	urs af	ρ	3 Widowed 4 Divor	oed If Yes,	Give r Dates:		1 ☐ Yes 2 💢 o	Specify:		Specify:	Black
21215-0036	filed within 72 hours after Hygiene. other than "naturel", or Ite ant, the Medical Exernine	Completed	15. Dece (Specify only hi	dent's Education ghest grade complete	d)		dent's Usual Decupa		f working	16b. Kind of Busine	ss/Industry
121	within ne.	ш	Elementary/Secondary (0-1	T	(1-4or 5+)	life. I	OO NOT use retired			CONS	tuction)
0	filed y Hygie other 1		17. Father's Name (First, Mide	dle, Last)	cus		<i>U</i>	18. Mother's	Name (First, Middle, I	Maiden Sumame)	aquere
<u>lan</u>	lid be fental rked c	To Be	Clarence	Jone	S			Ha	Hie A	· Hor	nes
	2 should and Mer is marke		19a. Informant's Name/Relati	onship (Type, Print)	G-11 \	19b. Mailin	g Address (Street a	and Number	or Rural Route Number	City or Town, State	a, Zip Code) 2/20 G
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Menth Hygiens.  If item 27 is marked other than "naturel; or items 23a or 28a-f show it it item 27 is marked other than "naturel; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Clarence	JONES	tather)	819	+ Moc	KINO	bird (	ave,/c	WSON, MD
00	Pages intent of hint: If ite		20a. Method of Disposition  1 □ Burial □ Cremati  4 □ Donation 5 □ Othe	on 3 Removal fro	m State	cemetery, cren	sition (Name of natory or other place	e)	12/13/05	20c. Location - City	or Town, State
Baltimore,			4 Donation 5 Othe		10	THEN!	. Name and Addres	Sef Facility	1 1 1	Dati	Ca-vice
Ã	permit. Departr imports any inj		1150 C	ato 1	N0136	03	augh	Joan	B. Id Ba	lto MD.	11212
			23a. Part . Enter the disease shock, or heart failure.	, or complications the List only one cause o	at caused the deat	h. Do not ent	er the mode of dying	g, such as ca	rdiac or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	_ a	STAB W	ound	to cHe.	st			Driset and Death
	/Medical Examiner		resulting in death)	Due	to (or as a conseq	uence of):	-				
Ļ	1.55	Э	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due	to (or as a somewy	dence of):					
V	xecuted and II-transit	Examiner	that initiated events	G							
,092	te be executed ysicien and te burial-transit		resulting in death) Last	Due	to (or as a consequ	uence of):					
		dlcal		d							-
Вох 68	leath certificat ettending phy I for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna		1= .			23d. Date of	delivery
B	a deatl	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No		e birth 2 ∏Fetai egnant at time of de known		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	The law requires that the death certifica ate has been signed by the ettending ph page 2 should be detached for use as the	by Physician/Med	9 ☐ Unknown Part II. Other significant cone			ulting in the ur	adarhina nausa awa	o in Part I	22a Did tob	acco use contribute	to the serves of death?
Vital Records,	signe d be c	d by	Partii, Other significant com	antona community (	death but not resi	ulting at the ut	idenying cause give	en in Part I.	1 _ Ye		to the cause of death?  Probably 4 _Unknown
cor	w required should	lete							24a. Was ar		autopsy findings available
æ	The la te has age 2	Completed							autops	y prior t	o completion of cause of
ita	strifica ctor. p	BeC	25. Was case referred to med examiner?	lical				26. Place of	Death Check only one		es 2 No
<u></u>	Attending Physicien: r death. sctor: After this certifice by the funeral director.	၉	1 X Yes 2 □ No			ER/Outpatien		4 🗆 140151	ng Home 5 Reside		pecify)
Division of	ding f h. After funer	ţ	27. Manner of Death  1 Natural 5 Per		te of Injury onth, Day Year)	28b. Time of Injury	Work	rat ⟨? Yes 2 ⊠No	28d. Describe ho		
Visi	Atten r deat ector: by the	flca	3 Suicide 6 □ Co	uld not be 28e, Pl	ice of Injury - At ho	ome, farm, stre			281 Location (St	Teet and Number or	Dum I Pouto Alumbas
٥	tal or A rs after al Direct ed in by	Certification;	Homicios	Du	lding, etc. (Specif)	verid	erco		Gilles 11	State) AGENIN	11 Count
	Hospi 4 hou Funer ely fill		(Check only 2. Medi	cal Examiner: On the	basis of examina	wledge, death	occurred at the time	ne, date and pointon, death	place, and due to the ca	use(s) and manner ite and place, and d	as stated. ue to the cause(s)
	To the Hospital or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	one) 29b. Signature and title of cer	and m	anner stated.	/	29c. License			d. Date signed (Mo	
	F ≯ F 8		•	1 21	1/		0.0	ME			
	0		30. Name and address of per	1/	•	п 23а) (Туре,		C.M.E.	D.	ECEMBER 4	, 2005
	3			um. Tin		-	111 PENN	STREET	BALTIMORE	, MARYLAND	21201
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DHM	MH 17 Rev 1/20		DEC	0 7 2005	ELECTION .	S. A.	freele	-5,410, A-20,	nedycomena o eser		
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				State of Mary				-	-	
_			1 - For State Registrar	•	•	tificate of L		, ,	ene 2005	39444
, S	Physici	an	Decedent's Name (First, Middle, Last     William Jose		Zonoule-	Q		2. Date of Deat	Day Year	3. Time of Death
	/Medio	cal	William Jose 4a. Facility Name (If not institution, give	-	Konopka	Sr.	Location of Death	12	2 206 4c County of Dea	
	EXAIIII	ier	Flanklin squal	e Hostit	-21	ROSE	HOV P.		Rait	-imare
*	Funeral Director		5. Social Security Number 6. Se	x 7. Age (In	yrs. last birthday). 83 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February	9. Bir	thplace (State or Foreign buntry)
15			Usual Residence of Decedent					rcacury	11,1522	Maryland
	Marylan fshow	jo	10a. State 10b. County  Maryland Baltimon		c. City, Town or Lo	cation				10d. Inside City Limits 1 ☐ Yes 2 💆 No
	or 28s	Funeral Director	10e. Street and Number			10f. Zip Code		10	0g. Citizen of What Co	ountry?
	ath will	ralD	105 Old Maple Cour	ct		21221			USA	
	ltame	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever Armed Forces? 1 X Yes 2 No	in U.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	nican Indian, e, etc.
° → M 5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. It has the marked other than "natural", or Itame 23e or 28s-f show other traumatic event, the Medical Examination at the notified at	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2X No	Specify:		Specify: Wh	ite
] i o_f 15-003	in 72 h n "natu de alica	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Deced (Give life. L	ent's Usual Occupa kind of work done o OO NOT use retired	ation during most of work )	ing	16b. Kind of Business	Industry
212	filed with Hygiene other tha	Com	Elementary/Secondary (0-12) 7 years	College (1-4or 5+)		enter			Constructi	on
and	be filed that Hygie d other	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
ھی تے	2 should be f and Mental h is marked of aumatic eve	ဥ	Joseph Konopka  19a. Informant's Name/Relationship (T)	rpe. Print)	19b Mailin	Address (Street a		Abramow	Ska City or Town, State, I	Zin Codo)
P K	1 and 2 s Health ar tem 27 is		William J. Konopka	a Jr. son	1929	Ormand F	Road, Dun			
イono Paltimore,	Pages 1 nent of Hu int: If iter iry or oth		20a. Method of Disposition 1   ↑ Burial 2 □ Cremation 3 □ F	TOTTIONAL ITOTTI CILATO	Ob. Place of Dispos cemetery, crem		_	mber	20c. Location - City or	
o altin	permit. Pages Depertment of Important: If i eny Injury or once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		St. Stani		9, 4	005	altimore,	
× 8	Per Per Per Per Per Per Per Per Per Per		Inthony (	:- Corne	llu ?	onnelly F 110 Solle	Funerál H ers Point	ome Of D Road, D	undalk,P.A undalk, MD	21222
*			23a. Parti. Enter the disease or comp shock, or heart failure. List only o	ications that caused the ne cause on each line.	death. Donot ente	r the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a con	X AI	rest	-			Onset and Death
ie	Examiner		Sequentially list conditions	CHF	isaquarica (i).					
19	led nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Mue to for as a con	isaquarica of).				1	
o,	be executed icien and burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a cor	nsequence of):					
8760	0 % 0	Ilcal		1						
89 x	certific iding p	/Mec	IF FEMALE:	3c. If yes, outcome of pr	agnancy					
Box	he death the atter hed for u	by Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year
P.O.	that the deat ed by the atte detached for	Phys	9 Unknown	9□ Unknown	A Mi i M			00. 00.		
rds,	se ge		Part II. Other significant conditions con	imbuting to death but no	r resulting in the un	derlying cause give	in in Part I.	1 Tes	acco use contribute to s 2 ØNo 3 ☐ Pri	the cause of death?  bably 4 Unknown
O CO	aw requir as been si 2 should	Completed						24a. Was an	24b. Were au	topsy findings available completion of cause of
<u>~</u>	The laste has page	Com						autopsy perform 1 Yes 2	ed? death?	completion of cause of
Vita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		O# -	26. Place of Death	Check only one		
of	Phys	To	1 Yes 2 No	1 / Inpatient  28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of		4   Nursing Hor	me 5 Resider 28d. Describe how	nce 6 Other (Spec	city)
ion	Attending I death. ctor: After y the funer	atlor	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	28c. Injury Work M 1 \( \text{Y}	? ′es 2 □ No			
Division of Vital Records,	or Atterde after de Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, stre	et, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
	To the Hospitel or Atlending Physicien: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	sician: To the best of my	knowledge, death	occurred at the time	e, date and place, a	and due to the cau	use(s) and manner as	stated.
	the H	Medical		ner. On the basis of exar and manner stated.	mination and/or invi					
	To To COIT		29b. Signature and title of certifier	01000111	227.17	29c. License		7   29	d. Date signed (Month	n, Day, Year)
	7	1	30. Name and address of person who	mpleted cause of dean	(Item 23a) (Type, F	rint) _			21110	>
	$\sigma$		Ur. Suganthi		y9000 1	= louk 1	n squ	are DI	ive Bottim	of mp 21237
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 7 200	52 degistrar's S	ignature	all s	,			,

Amend item#5, perFh, G850, 12/14/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mary Dorothy Kesler 12/01/2005 8:40 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlestown Care Center Baltimore Baltimore County If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month Day Year) 10/23/1913 5. So218-010-0487 6. Sex 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 😾 F <del>213-01-0039</del> 92 Yrs. Director MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other then "natural", or Items 23e or 28e-f show other treumetic event, the Midical Examiner is ust be realified at 10d. Inside City Limits Director MD 1 Yes 2 □ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Maiden Choice Lane 21228 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ρ 1 ☐ Yes 2 XNo Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Caucasian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Hopkins Caulk Emma Anna Becker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 siment of Health an tent: If Item 27 is jury or other treur William D. Kesler 290 Brightfield Dr., Manchester, MD. 63021 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State permit. Page Department of Importent: If eny Injury of Baltimore County Crematory 12/05/2005 Baltimore, MD. □Denation 5 □ Other (Specify) re of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> HUbbard Funeral Home, Inc. 4107 Wilkens Ave/. Baltimore, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician blood due to AV malformation a. GT /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner executed use as the burial-transit that initiated events the attending physician and resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown detached 9☐ Unknown signed by to d be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Sursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 🗌 Inpatient 2 2 ER/Outpatient 3 DOA funeral 27. Manner of eath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification: 1 Natural
2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A completely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P30989 0x0xmber 03 2005 address of person who completed cause of death (Item 23a) (Type, Print) III Maiden Choice In Catonsville MD

DHMH 17 Rev 1/2001

State

Registrar

1 Corporter MD

7 2005

			1 - For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment rtificate			ind M	ental Hy	giene Reg. No.	005		3944	6
	Physici	ian	1. Decedent's Name (First, Min	ddle, Last) KAVANAC	6.13						2. Date of De Month	Day	Year		3. Time of Dea	
	/Medic Examir		4a. Facility Name (If not institu		ber)	-	4b. City, To	own, or L	ocation of		Novemb		County of De		7.30%	1
				= MARYLAND		IL (EMER		TIMOR		MD						
	Funeral Director		5. Social Security Number  577-44-9097  Usual Residence of Decedent	1□M 2 (F	7. Age (In yrs. 79	last birthday) Yrs.	If Under 1 Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da 03/11	th ly, Year) /1926	(	irthpla Co <i>untr</i>	ce (State or Fo y)	reign
	ryland how		10a. State 10b. Cou		10c. Ci	ity, Town or Lo	cation							10	d. Inside City L	imits
	8a-1 s	Director		ce Georges	Lau	rel	_								1 ☐ Yes 2 €	₹No
	with the or 2	Dire	10e. Street and Number				10f. Zip C					10g. Citiz	zen of What (	Countr	y?	
	death ms 23	Funeral	8301 Ashford E	12. Was Dece	dent Ever in L	J.S. 13. \	2070 Was Deceder	nt of Hisc	panic Orig	in? (Spec	cify Yes or No	)- 1	14. Race - Am			
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23e or 28e-f show any injury or other traumatic event, the Modical Exam as Invalled in 2010e.	b	1 Never Married 2 N 3 Widowed 4 Divord	If Vas Give	2. <b>2</b> (No		f Yes, specify I ☐ Yes 2]		Mexican, Specify:	, Puerto F	ican, etc.)		Black, Wh Specify: Wh:			
5-0	72 ho natur	eted	15. Deced (Specify only hig	dent's Education		(Give	lent's Usual (	done dui	ion ring most	of workin	g	16b. Kir	nd of Busines	s/Indu	stry	
121	12 should be filed within h and Mental Hygiene. 7 is marked other then "traumatic event, the Med	Completed	Elementary/Secondary (0-12		4or 5+)	life. I	DO NOT use t Anal	retired)	J			Fede	ral Go	vei	rnment	
d 2	illed Hygir othar	Be Co	12 17. Father's Name (First, Midd	fle, Last)		Budge	L Allai		8. Mother	's Name	(First, Middle,	Maiden S	Sumame)			
/lar	wild be Menta arkad artic ev	ToB	Thomas Kavana	igh				1	Kathr	yn E	lammer					
Maryland	12 sho		19a. Informant's Name/Relation								Route Number				Code)	
	1 and Healti tam 2		Thomas Kavanagh 20a. Method of Disposition	n/Nepnew	20b. I	Place of Dispo	sition (Name	of	Ţ	-	olumbi		D 2104 cation - City o		n. State	
OE I	Pages lent of nt: If it		1 ☐ Burial 2 ☐ Crematic		tate	cemetery, cren esapeak	-		1		ec 5		sville,			
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Servi		CII	22	. Name and	Address	of Facility	,	Alterna					
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90,	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	С.	r as a consec									7		
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.O. Box	The law requires that the death certificate be executed tto has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of c	al death 3	Ectopic preg Other (spec					2:	3d. Date of de Month	,	ay Year	. )
ords, P.	w requires that been signed b should be deta	by	Part II. Other significant cond	litions contributing to dea	ath but not res	sulting in the ur	nderlying cau	se given	in Part I.		23e. Did to		se contribute No 3□F		cause of death	
Vital Records,		Completed									24a. Was autop perfo 1 Yes	an osy rmedo 2. No	24b. Were a prior to death?	comp	y findings avail iletion of cause	iable e of
Ĭ.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medi examiner?  1 \( \subseteq \text{ Yes}  2 \subsete \text{ No} \)	Hospital:		15D/0	• • • • • • • • • • • • • • • • • • • •	Other:			(Check only o					
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sior	Attanding I ar death. actor: After by the funer	atlo		stigation	, Day ( tal)	Injury	М		s 2 🗆 N	lo						
Division	afte Diji	Certification;		ald not be 28e. Place of building	of Injury - At h g, etc. (Speci)	ome, farm, stre fy)	et, factory, o	office		28	3f. Location (5 City or Tow	Street and vn, State)	Number or F	Rural F	Route Number,	
	Hos Funda ely	edical	(Check only 2   Medic one)	ying Physician: To the bas al Examiner: On the bas and manne	sis of examina or stated.	ation and/or inv	estigation, in	my opin	iion, death	occurred	d at the time, o	date and p	place, and du	e to th	e cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of certi	ifier			29c. L	icense n	number			29d. Date	signed (Mon	th, Da	y, Year)	_
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5			30. Name and address of personal description of the second	in MD	of death (Iter	7 23a) (Type, I	Gree	ue	57,	1	altim	we.	MD	2	1201	
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State of M	aryland /	Department	of H	ealth and M	lental Hvqi	ene

n	Gregory	7 K	1 _ State	State of Ma			ent of Health and ate of Death	Mental H	()	nne	201.1.7
	3. m.		Registrar  1. Decedent's Name (First, Middle,	ast)		Hunce	ile oi Dealii	2. Date of	Reg. No.	000	39447
3	Physici							Month	Day	Year	3. Time of Death
	/Medic Examin		John Kreson  4a. Facility Name (If not institution, c	ive street and number)		4b Cit	y, Town, or Location of De			0, 2005 County of Death	12:15 P <sup>M</sup>
-	Examili	er	6704 German Hil	·			timore	atti		ı/a	1
	Funeral	Migua			(In yrs. last birthday	) If Unc	ler 1 Year If Under 24 H		Birth	·	place (State or Foreign
14.	Director		dik	1 <b>∑</b> M 2□F	46 Yrs.	Month	s Days Hours Mi	n. (Month,	Day, Year)	Cor	unk
	D.		Usual Residence of Decedent					may 2	1 1 1 2 2	2	
	ehow	_	10a. State 10b. County		10c. City, Town or L						10d. Inside City Limits
	Ba-1	cto	MD Balt	more	Bal	timo	re				1 □ Yes 2 No
	hours after death with the Maryland tural; or Items 23s or 28s-f ehow at Examiner must be notified at	Director	10e. Street and Number			10f. 2	Ip Code		10g. Citize	on of What Cou	intry?
	a 23s	Funeral	6704 German Hil				21222			USA	
	Item Item	ū	11. Marital Status un 1 □ Never Married 2 □ Married	Armed Forces?	ver in U.Sunk 13.	If Yes, sp	edent of Hispanic Origin? ecrfy Cuban, Mexican, Pu	(Specify Yes or orto Rican, etc.)	No- 14	<ol> <li>Race - Ameri Black, White</li> </ol>	
36	irs af	by F	3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 🗆 Yes	2  ▼ No Specify:		s	pecify: wh:	ite
9	72 hours "natural", dical Exa	pe	15. Decedent's		16a. Dece	edent's Us	sual Occupation	1	- 16b Kind	f of Business/Ir	ndustry 1
215	within 72 ene. than "nat	ple	(Specify only highest (Secondary (0-12)	rade completed) College (1-4or 5-	(Give	e kind of v	vork done during most of w use retired)	orking un	K   I SO I TAIL	01 04011103411	unk
21	THE R. LEWIS CO., LANSING, LAN	Completed	unk	unk							
Baltimore, Maryland 21215-0036	be filed tal Hygi d other event, II	Be	17. Father's Name (First, Middle, La	st)			unk 18. Mother's N	ame (First, Mid	dle, Maiden S	umame)	unk
ryla	should be and Mental marked o	<sup>L</sup>	10a Jafarrantia Nama/Dalatianakia	(Time Brint)	405 14.7						
Ma	17 L	7	19a. Informant's Name/Relationship	(Type, Print)			ss (Street and Number or I			Town, State, Zi	p Code)
Ġ,	1 an Heal em 2 ther	1 3	O.C.M.E.  20a. Method of Disposition		20b. Place of Disp	osition (N	un Street Ba	ltimore		21201 Ition - City or T	own State
و	8 = 5		1 ☐ Burial 2 ☐ Cremation 3	Removal from State	cemetery, cre				200. 2006	ttion - City or 1	Own, State
Ħ	artmer artmer ortant Injury		4 □ Donation 5 ☒ Other (Special Service Lice		1	2 Name	and Address of Facility		-		
Ba	permit. Departm Importal any Inju		21. Sign ture I runeral Service Lic Ronald S	Wale Dire	ctor S	tate	Anatomy Boar nore, MD 212	rd 655 V	V. Balt	imore S	Street
	٠.		23a. Part1. Enter the disease, or co sheck, or heart failure. List on	mplications that caused to	he death. Do not en	iter the mi	ode of dying, such as cardi	ac or respirator	y arrest,		Approximate
	Physician		Immediate Cause (Final								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a	consequence of):	_OF	CHRONIC	ALC	HOL1:	Sin	
1	Examiner				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,						
	161 A	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):						
	be executed icien and burial-transit	Examiner	that initiated events	С.							
o o	e exe en ar irial-t	EX	resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate be executed physicien and the burial-transit	dlcal	•	d							
9	ng pt	Med	IF FEMALE:								
Вох	death certificate e attending phys d for use as the	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2		⊒Ectopic	pregnancy		230	d. Date of delive	•
0	the dea y the a	Physician/Me	1 Yes 2 No	4□ Pregnant at ti 9□ Unknown	me of death 5[	Other (s	specify)		-	Month	Day Year
<u> </u>	that the de led by the a detached t		Part II. Dther significant conditions	contributing to death but	not resulting in the u	ınderlyina	cause given in Part I	23e Di	d tobacco use	contribute to t	he cause of death?
Records,	se us	۵			y u.o c	ao.iiyiiig	occoo giverni ratti.		Yes 2□		pably 4 ZUnknown
Ö	w requir been s should	ete									Jaciy 42301Kilowii
Ę	has has	Completed							topsy	prior to co	ppsy findings available mpletion of cause of
	ician: The t certificate ha ector, page							1. EXXes	rformed? 2 □ No	death?	2□ No
Vital	oding Physician: th. : After this certifica funeral director, ic	Be	25. Was case referred to medical examiner?	Hospital:			011	eath (Check onl			
	Physical distribution	<u>د</u>	1XXYes 2 No 27. Manner of Death	I 🗆 Inpatien	2 ER/Outpatie		OA 4 Nursing				vat scene
on	ding h. After fune	ton	1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) Injury	M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	280. Describ	e how injury o	ccurrea	
S	l or Attending after death. Director: After	flca	3 ☐ Suicide 6 ☐ Could not	be 200 Place of Isius	y - At home, farm, st			28f Location	(Street and h	lumbas as Que	ul Route Number,
Division of	afte Dir	Certification:	4 Homicide determine	building, etc.	(Specify)	. 501, 14010	,,, 51100	City or	own, State)	ישייים אין איניים איניים איניים	noule ivumber,
	Hospital		29a. Certifier 1 ☐ Certifying F	hysician: To the best of	my knowledge, deat	h occurre	d at the time, date and place	e, and due to the	10 Callen/e) an	d manner se s	tated
	To the Hospital within 24 hours To the Funaral completely filled	Medical	(Check only 2 Medical Expone)	miner: On the basis of e and manner state	xamination and/or in	vestigatio	n, in my opinion, death occ	urred at the tim	e, date and pl	ace, and due to	the cause(s)
	To the Youthin 2 To the complet	M	29b. Signature and title of certifier			25	c. License number		29d. Date s	igned (Month,	Day, Year)
			> Yell	)			O.C.M.E.		Nove	mber 21	2005
		-	30. Name and address of person who	completed cause of dea	ith (Item 23a) (Type,	Print)			2.000		., 2007

State Registrar 31. Date filed (Month, Day, Year) DEC 0 7 2005

ANA

RUBIO MD 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature

			For State Registrar	State of Ma	ryland		artment <i>tificate</i>			ind Me	-	_		0011	$\cap$
			Decedent's Name (First, Middle, Last	:()			imouto	010	Catif	2	. Date of De	Reg. N		3. Time of De	ath
	Physic /Medi		Wanda J. Kriss							r	Month PECE M	hes	$52\alpha$	5 1:30	PM
	Exami		4a. Facility Name (If not institution, give	street and number)	1 1		4b. City. To	own, or L	ocation o				c. County of Dea		
			5. Social Security Number 7 6. S		tal	- 4 h : - 4 h - 1	K	Se	0	e			Balt	more	,
¥ /	Funeral Director			M 2.2XTF / Mrge	(in yrs. ia. _81	st birthday) Yrs.			Hours	Min.	Date of Bir (Month, Da	y, Year	)   C	thplace (State or Fo	oreign
	n negge		Usual Residence of Decedent							<i>F</i>	prii	19,	1924 Okl	ahoma	
	arylar show	7	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City L	
	ith the M or 28a-f	Director	Maryland Baltimor	9	Es	sex	101 7 0							1 ☐ Yes 25	<b>₩</b> ∘
	Sa or		15 Branch Street				10f. Zip C						itizen of What Co	ountry?	
	death	Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. V			panic Orig	in? (Specif	fy Yes or No		J.S.A. 14. Race - Ame	ncan Indian,	
5-0036	1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. 1 fleath and Mental Hygiene 1 flem 27 is marked other than "natural, or items 23a or 28a-f show other treumatic event, in	by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X X 4 If Yes, Give Year or Dates:	0	1	Yes, specify		Mexican, Specify:	Puerto Rio	can, etc.)		Black, Whit		
5-0	72 ho 'natu	eted	15. Decedent's Ed (Specify only highest gra	ucation de completed)		16a. Deced	lent's Usual (	Occupation of the control of the con	on rina most	of working		16b. F	Cind of Business	Industry	
da 2121	within ane. Ihan	Completed	Elementary/Secondary (0-12)	College (1-4or 5+			kind of work OO NOT use	retired)		or woming		m. 1			
D 20	Hygie therit		17. Father's Name (First, Middle, Last)			Opera	cor	11	8 Mother	's Name /F	First, Middle,		ephone		
land 212	lid be lental ked c	To Be	Claud Jackson						Evy	Lil		Walder	ourname)		
Waryland	and M	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (5					er, City	or Town, State, 2	Zip Code)	
_	and 2 Balth in 27 i		Douglas Kriss (	Son)		19912	Mikes	Way	, Pa	rkton	, Mary	ylan	nd 21120		
> ore	ges 1 t of Ha if iter or oth		20a. Method of Disposition 1 □ Burial 2XX cremation 3 □	Removal from State	cen	netery, crem	sition (Name natory or other	er place)		Date			ocation - City or		
Fi55	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than sny injury or other treumatic event, ITE M. once.		4 □ Donation 5 □ Other (Specify	)	Bayv	iew C	remato	ry,I	nc.D	ec.9,	2005	Bal	timore,	Maryland	l
Bal	Deparimon impo	6	21 Signature of Funeral Service Licen	900		22.	Name and	Address Bruz	of Facility dzin:	ski F	unera]	L Ho	me, P.A		
7		_	23a. Party Enter the disease, or comp	lications that caused t	he death.		14U/ U	TO E	aste.	III_AV	enue.	ESS	ex, Mar	yland 212 Approximate	21
	Physician		Immediate Cause (Final	one cause on each line	). •			, ,						Interval Between Onset and Deat	
	/Medical		disease or condition resulting in death)	a. Due to (or as a	conseque	nce of):									
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	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	nce of):									
^	be executed sicien and burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a	conseque	nce of):									
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.89	tificate ng phys as the	ledio		u											
30X	eath certific attending p	an/h	200. Was decedent program	23c. If yes, outcome of 1 ☐ Live birth 2	pregnanc		Ectopic preg	nancv					23d. Date of deli	very	
0.	the at	/sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at ti 9□Unknown			Other (speci						Month	Day Year	
Division of Vital Records, P.O. Box 6	or Attending Physician: The law requires that the death certificate be executed the death. Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	Part II. Other significant conditions co	ntributing to death but	not resulti	na in the un	derlying caus	i nevin es	in Part I	-	23a Did to	bacco I	use contribute to	the cause of death	-2
ds,	uires tha signed I Id be det			g			oonying odd.	30 givaii i	iii aiti.		1 □ Y		<b>V</b>	bably 4 Dunkn	
Ō	s been si should	Completed								_	24a. Was a		-	opsy findings avail	
Re	The lav	mo								_	autop	sy med? 2 X No	prior to c	ompletion of cause	of
ital	ysician: Th	Bec	25. Was case referred to medical examiner?				-	20	6. Place o	of Death (C	1 ☐ Yes heck only or	-	1 Ll Yes	2□ No	-
of V	Physic this ce al dire	۵,	1 ☐ Yes 2 No	Hospital: 1 Inpatient		VOutpatient		Other	4 🗆 Nurs		-		6 ☐Other (Spec	ıfy)	
n C	ding Ph h. After th funeral	ilon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	rear) 28	Bb. Time of Injury		Injury at Work?			. Describe h	ow injur	y occurred		
isi	of or Attending after death.  Director: A din by the fu	ficat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury	r - At home	a farm stre	M factory of		2 □ No	294	Location (E	troot an	od Alumbas as Di	al Route Number,	
Ş	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	Certification:	4 Homicide determined	building, etc.	(Specify)					201.	City or Tow	n, State	)		
	To the Hospitel c within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the best of ner: On the basis of e and manner state	xamination	edge, death nand/or inve	occurred at t estigation, in	my opini	data and on, death	occurred a	due to the matthe time, d	late and	thid make or us I place, and due	oluteu. to the cause(s)	
	To the within 2 To the complet	Σ	29b. Signature and title of dertifier				Λ	icense nu					te signed (Month	- '	
			Mun	1			Ke	950	007			12	-5-	05 1p,2173	
Pa	, 1 5		30. Name and address of person while	maleted cause of dea	th (Item 23	Ba) (Type, P	rint)	C	ν .	Λ.	10 A	11.	. 14	40	,
16	Sta	te	31. Date filed (Month, Day, Year)	32 Registrar	Signatur	110	nuli	N	yval	e Vi	VE, 12	alti	more, h	11,2173	,/
	Registra			1			land .								
DH	MH 17 Rev 1/20	01	DEC 0 7	2005	100	0. 19	A CAN								
					(	ORIGIN	AL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Day
December 2, **Physician** Mary Jane Kennelly 2005 7:46A /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y Dec. 10, Year), 1940 9. Birthplace (State or Foreign Country) New Jersey Funeral 1 ☐ M 2 🗓 F Director 156-44-2882 64 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location rai', or iteme 23a or 28a-f ehow Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland | Montgomery North Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10704 Gloxinia Drive 20854 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Chief Executive Officer Foundation Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I ၉ James Peter Campbell Agnes Leona Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i James P. Kennelly/Husband 10704 Gloxinia Drive, North Bethesda, MD 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery 20a. Method of Disposition 20c. Location - City or Town, State December 5, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2005 Crematorium, Inc. Bethesda, Maryland 21. Signature of Figure all Service Licentee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 M00803 , ہیں Bethesda, Maryland 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac Arrest /Medical Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease Saventially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform certificate 1 ☐ Yes 2 🔀 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🛛 ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 X No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled in 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier-29c. License number 29d. Date signed (Month, Day, Year) 128 December 3, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

James R. Cooper, M.D.

DEC 0

31. Date filed (Month, Day, Year)

32. Registrar's Signature

7 2005

3948 Washington Street, Kensington, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 20a b. c. 22 per fb 9850 12-7-05 vt.

State of Maryland Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Na. UU 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 1:55 PM 2, 2005 December /Medical Richard Lewis 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ₹M 2 □ F Months Days Hours Yrs. 281-66-6792 47 Sept 18, 1958 Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1√ Yes 2 No Funeral Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 801 N. Lakewood Avenue 21205 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐X/es 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status the Medical Exeminer 1 Never Married 2 Married Maryland 21215-0036 5 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than College (1-4or 5+) Elementary/Secondary (0-12) 11 0 cook Pages 1 and 2 should be filed w riment of Health and Mental Hygien riant: if item 27 is marked other ti jury or other traumatic event, In restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk Harry Vandergriff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard J. Lewis/son 815 Timberline Trail Sagamore Hills, OH 44067 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Pages
Department or
important: if i
any injury or
once. Chesapeake Crem. Inc.12-8-05 4 □Donation Specify) Beltsville, Md. 22. NGAFAAStephen D. Lohrmann, P.A. State Anatomy Board 652, W. Paltimore Street 21. Signatur of Funeral Service Director Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the disease or complications that caused the death. Green Pastures Dr.

Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition resulting in death) ung cancer **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Due to (or as a consequence of): sician a Box 68760 as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No rector, page 2 1 Yes 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours a
To the Funersi I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 838 NEutaw St Bullinive Hospice

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

DEC 0 7 2005

32. Registrar's Stonature

David Lovelace 05-07887 NJM

		stata Unpend Item	23a,27,28a-:	f per me	rifficate of D	05 tras			39451
Dhuniai		1. Decedent's Name (First, Middle, La	ist)				2. Date of Dea	th Day Ye	3. Time of Death ar
Physici /Medio		David Lovelac	e			I	November	c 22 200	5 2059 <sup>M</sup>
Examin		4a. Facility Name (If not institution, gir	e street and number)		4b. City, Town, or L	ocation of Death		4c. County of D	eath
		St. Agnes Hospit	al		Balti				
Funeral			SEM OFF	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreign Country)
Director		210-04-7001	1⊠M 2□F	39 Yrs.			June 26	, 1966 M	aryland
Z * Z		Usual Residence of Decedent  10a. State 10b. County	1	IOc. City, Town or Lo	ocation				10d. Inside City Limits
aryla ehov	_	MD		Baltime					1√2 Yes 2 No
8a-f	ctc			Dalting			1.	On Citizen of Miles	
5-UUSO 72 hours after death with the Maryland naturel', or Items 23e or 28e-f ehow disal Exandrer must be notified at	i Director	10e. Street and Number 2918 Walbrook A	venue		10f. Zip Code	21216	'	og. Citizen of What USA	Country?
after death w or items 23e	Funerai	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Spe	cify Yes or No-	14. Race - A	American Indian,
ter d	표	1 ☑ Never Married 2 ☐ Married	Amed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give				Rican, etc.)		Vhite, etc.
Maryliand ZIZID-0030 nd 2 should be filed within 72 hours alt lith and Mantal Hygiene. 27 ie marked other then "naturel", or rtraumatic event, ir e Medical Exami	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give A Year or Dates:		1 □ Yes 2 ∏ No	Specify:		Specify:	b1ack
72 hours "naturel",	Completed	15. Decedent's E	ducation	16a. Dece	dent's Usual Occupati	ion		16b. Kind of Busine	ess/Industry
7 Land	pie	(Specify only highest gi	College (1-4or 5+)	life.	kind of work done du DO NOT use retired)	ring most or workii	ng		
I within light	E		unk		ntractor			commer	cial
be filed vital Hygie of other in	BeC	17. Father's Name (First, Middle, Las	1)		1	18. Mother's Name	(First, Middle,	Maiden Surname)	
id be ked ked	To B	Milton A. John	son Jr			Tane 1	Love1ac		
shou nd M mar	-	19a. Informant's Name/Relationship		19b. Maili	ng Address (Street an				te, Zip Code)
Nic 2 Ith a 1		Karen Johnson/si	ster	2918	3 Walbrook	Avenue I	Raltimon	ro MD 2	1216
ore, Maryland stand 2 should be fi of Health and Mental H litem 27 is marked ot r other traumatic ever		20a. Method of Disposition		20b. Place of Dispo				20c. Location - City	
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 🎇 Other (Spec	Removal from State	Cemetery, cre	matory or other place)	' i			
SAITIMOTE, sermit. Peges 1 ar Depertment of Hea mportant: If Item any injury or othe				. 2	2. Name and Address	of Facility			
baltimo		21. Signature of Funeral Service lice Ronald	Wade Digo	otorS	tate Anato altimore,	my Board	655 W.	Baltimor	e Street
Physician /Medical Examiner physicien and bhysicien and steep physicien ai Examiner	shook, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Narcotic  Due to (or as a  b		ne Intoxic	ation			Interval Between Onset and Death	
BOX to sath certification of the use as for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)	****		23d. Date of Month	delivery Day Year
Cords, P.O.  requires thet the de been signed by the should be detached	Ď	Part II. Other significant conditions	contributing to death but	not resulting in the i	underlying cause giver	n in Part I.			te to the cause of death?
Cord v requir been si	Completed								
Heco	pie						24a. Was a autop:	sv prior	e autopsy findings available to completion of cause of
The The page	5						perfor Yes	med? deal	n? Yes 2⊡No
Tiffice	Bec	25. Was case referred to medical				26. Place of Death	Check only or	ne)	
ysic is ce	10	examiner? 1 <b>∑</b> Yes 2 ☐ No	Hospital: 1   Inpatien	t 2 🙀 ER/Outpatie	nt 3 DOA Other	4 Nursing Ho	me 5 🗆 Resid	ence 6 Other (	Specify)
erth Berah		27. Manner of Death	28a. Date of Injury		of 28c. Injury Work?	at :	28d. Describe h	ow injury occurred	unk
e fur Att	atio	1 □Natural 5 □ Pending 2 □ Accidentinvestigati	E ( )	8:00		es 2 XNo			
는 전투 등	edicai Certification:	3 ☐ Suicide 6 🗖 Could not 4 ☐ Homicide determine	be 300 Glass of Injur	y - At home, farm, s (Specify)	treet, factory, office			treet and Nursee D n. State) 208 D re. Mary 1	r.Rural Route Place
Hospital 24 hours 2 Funerel (tely filled	caic	29a. Certifier 1 Certifying I	Physician: To the best of aminer: On the basis of	my knowledge, dea	th occurred at the time	date and place	and due to the o	auco(c) and manne	ar ac stated
To the H within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stat	ed.	29c. License			29d. Date signed (N	
, ¥ 5 8	-	700	1-216	2					
		Caron	COVI	\	OCME	<u></u>	N	ovember,	23, 2005
	i	30. Name and address of person wh	o completed cause of de	ath (Item 23a) (Type					
		CABILICO	CAM	's Signature		ın Street	Balti	more, Mar	yland 21201

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 08:35 M Year **Physician** Dorothy M Lamk

4a. Facility Name (If not institution, give street and number)

Both Secours Hospital Lamb December 5 2005 /Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner # Under 1 Year | # Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day | A Day 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 78 Yrs. 1 M 2 F 246 - 26 - 4995 Usual Residence of Decedent Director North CanLina 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "natural", or items 23s or 28e-f show traumatic event, its Modical Examinar must be notified at Baltimore 1 Yes 2 No mD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21233 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ⊆ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No 3 Widowed 4 □ Divorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene." The marked other then "n. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Care Provider Day Care 17. Father's Name (First, Middle, Last)
Jimmy Stevens 18. Mother's Name (First, Middle, Maiden Sumame) Mandy Satchell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m eny Injury or other traum QDGS. St. Delatha Fields Balto mo Ostena 21230 -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State →Burial 2 Cremation 3 Removal from State 12-14-05 Owings 4 □Donation 5 □Other (Specify)

21. Signature of Fulleral Service Lifense Garrison Forest V.A. 22. Name and Address of Facility BORY P. MOROY F/H 270 FREDHILTON PASS BALTO MO 21229 Shier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Coronary artery disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Candiac Dysonythmia, Diabetes Essential Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an itus, performe rmed? 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☑ ER Outpatient 3 □ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina 24 hours after death.

Funerel Director: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 29b. Signature and title of certifier Jurel 29c. License number 29d. Date signed (Month, Day, Year) MOMPH D0062183 December 5, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marganta B Jova MD. MPH 2000 West Baltonere Street-Baltonere, Maryland 21223 31. Date filed (Month, Day, Year) 2005 Signature Soules State Registrar

			1 = For State Registrar	State of Marylan	d / Department of    Certificate of		ntal Hygien	71115	39453
Jahren Committee	Physici /Medic Examir Funeral Director	cal	1. Decedent's Name (First, Middle, Last) 4a. Fecility Name (If not institution, give s 5 +   1 ' z a b e th 5. Social Security Number 6. Sex	Nursing Co	Ladzin enter 18a	or Location of Death  My C  If Under 24 Hrs. Hours Min. 8.	Date of Death Month Da & & Mun	year  7 3 , 2005  c. County of Death  N/A  9 Birthple  Count	3. Time of Death  11:10 A M  ace (State or Foreign ry)  yland
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23e or 28e-1 show important: If item 27 ie marked other then "natural", or iteme 23e or 28e-1 show eny injury or other treumatic event, the Medical Examinar must be notified at ance.	Completed by Funeral Director	Usuaf Residence of Decedent  10a. State 10b. County  Maryland N/A  10e. Street and Number  3308 Benson Avent  11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced  15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	12. Was Decedent Ever in U. Armed Forces?  1	S. 13. Was Decedent of If Yes, specify Cut  1 Yes 2 No  16a. Decedent's Usuaf Occu (Give kind of work done life. DO NOT use retire)	pation a during most of working ad)	10g. C Un (Yes or No- an, etc.)	itizen of What Count Lited Stat  14. Race - America Black, White, e Specify:  Kind of Business/Indu	es an Indian, old. White ustry as &
Baltimore, Maryland 21	Pages 1 and 2 should be filed winent of Health and Mental Hygien int: If item 27 Ie merked other thirty or other treumatic event, the	To Be Cor	17. Father's Name (First, Middle, Last)  Wactaw Checinsk  19a. Informant's Name/Relationship (Ty)  Janine Ladzinski  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	(Daughter)  20b. Pemoval from State	Microfilm  19b. Mailing Address (Stree 6322 Loring lace of Disposition (Name of emetery, crematory or other pla	18. Mother's Name (Fi  Jenn  t and Number or Rural Re  Drive Column  Date	irst, Middle, Maide nie Krieg oute Number, City nmbia, Ma 20c. L	er or Town, State, Zip	Code) 1045 wn, State
Balti		_	21. Sharture of Funeral Service Licenses  23a, Part 1, Enter the disease, or complianted in the shart failure. List only on Immediate Cause (Final	cations that caused the death	22. Name and Addr Duda - Ruck 7922 Wise	ess of Facility Funeral Hom P Ave. Dund ing, such as cardiac or re	ne of Dun lalk, Mar	dalk, Inc	
68760,	Physician per executed of physician and physician and as the burial-transit as the burial-transit as the principle.	Aedicai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or a))).	ience of):	_ • • • • • • • • • • • • • • • • • • •			years
P.O. Box	res that the death certifical igned by the ettending phy be detached for use as the	Physician/Med	## FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions con	3c. ff yes, outcome of pregna 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 Ectopic pregnand eath 5 Other (specify)		23e. Did tobacco	23d. Date of deliver Month [	Day Year
I Records,	v requires been sign should be	Completed by	anemia Anovexia	usion			1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No	24b. Were autop prior to com death?	sy findings available pretion of cause of
ion of Vital	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 Inspection 28a. Date of Injury (Month, Day Year)	28b. Time of Injury Wo			6 ☐Other (Specify) ury occurred	
Division	Hospital or Atte 24 hours after des Funerel Director itely filled in by th	edical Certification:	3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only one) (Check only one)	lician: To the best of my knowner: On the basis of examinat	me, farm, street, factory, office ) wledge, death occurred at the tool and/or investigation, in my	ime, date and place, and	City or Town, Stat	s and manner as sta	ted
2	To the complet	Med	29b. Signature and title of certifier  30. Name and address of person who co	and manner stated.  A mple stayte of death (Item	ro D.	se number	Dec	en ber	5,2005
	Sta	ate	31. Date filed (Nonth Day, Year)	32. Registrar's Signal	Hvenue,	Baltimo	re Mi	ary (and	21227

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrat Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2005<sup>ear</sup> **Physician** DEC. MARIE THERESE LARNED 3, 8:00 aM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 112 RIDGEWOOD ROAD BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. JULY 25 1925 Country) MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 F 220-14-8604 Yrs Director Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 ie marked other than "natural", or iteme 23a or 28a-1 ehow other traumatic event, the Madical Examinar must be notified at MD BALTIMORE 1X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 112 RIDGEWOOD ROAD 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 ie marked other than 'eny injury or other traumatic avant the any injury or other traumatic avant. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surmame) AUGUSTUS E. SATTLER MARIE V. CONNELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code PAT ELLIOTT daughter 112 RIDGEWOOD ROAD, BALTIMORE, MD. 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 12/6/2005 DRUID RIDGE PIKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** CORONARY ARTERY DISEASE years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 25 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | EP/Outpatient 3 | DOA 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No heral Director: A 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) D28987 12-5-05 30. Name and ad ress of person completed cause of death (Item 23a) (Type, Print) SPERLING 5601 LOCH RAVEN BI BALTO MD 21239 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27, **Physician** Month Phyllis Hindle Lock November 2005 3:29 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Bethesda Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Ye April II, 9. Birthplace (State or Foreign Country)
New York 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🗗 F Hours Min. 083-42-2577 58 Yrs. Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show The Mudical Examiners ust be notified at 1X Yes 2 No Director Maryland | Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 7006 Hillcrest Place 20815 United States Itams 23a by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other traumatic evant, 18. Mother's Name (First, Middle, Majden Sumame)
Constance diGiacona 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f Health and Mental James S. Hindle ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reinier Lock/Husband 7006 Hillcrest Place, Chevy Chase, Maryland 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages:
Department of H
Important: If its
any injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. \* 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland of Funeral Servi∂e Licensee 21. Signature Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase Inc. Inc. M00198 7557 Wisconsin Ave., Bethesda, MD 20814-3501 23a. Part1. End the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Arteriosclerotic Cardiovascular Disease disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attanding Physician: The law requires that the death certificate be executed ?4 hours after death. use as the burial-tran and Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760 by Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) 4☐ Pregnant at time of death ☐ Yes 2 🖾 No detached 9 Unknown 9 Unknown þ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1<mark>K</mark> Yes 2 No 1 ☐ Yes 21 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 🕅 Natural 1 ☐ Yes 2 ☐ No Diractor: / 2 Accident 3 🗀 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funaral D Medical 29a. Certifier 1K Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. tha 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 D34174 December 1, 2005 och 30. Name and agridress of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland Robert Rothstein, M.D. 31. Date filed (Month, Day, Year) 32. Regiarar's Signature 7 2005 Registrar

			1 - Stete Registrar	State o	of Maryla	•	artment of F rtificate of		Mental Hyg			
	_		Decedent's Name (First, Middle, La	st)			rimoute of	Douin	2. Date of Deat	h 4. 0	5	3. Time of Death
	Physici		Mercedes I.	Macken	1				Dec	01 2	Year 005	4:10 ам
	/Medic Examin		4a. Facility Name (If not institution, giv	e street and nu	ımber)		4b. City, Town, o	r Location of Deat	h	4c. County		
			Charlestown Care	e Cente	r		Cator	nsville			Balt:	imore
	Funeral		Social Security Number     6. S	ex □M 2 <b>X</b> F	7. Age (In yrs	. last birthday	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year)	9. Birthp	lace (State or Foreign
ш	Director		220-36-8756	⊔м 2Дуг	98	Yrs.			Aug 9,	1907		yľand
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or L	ocation				1	Od. Inside City Limits
	Aaryl Sho	5										1 □ Yes 2X No
	28a-	Directo	Maryland Baltim  10e. Street and Number	ore		Cato	nsville 10f. Zip Code		1,	0g. Citizen of W	/hat Cour	atry?
	72 hours after death with the Maryland natural', or Itams 23a or 28a-1 show Jical Examinat must be notified at	Ö	707 Maiden Choic	o Tano				20				
	ns 23	Funerai	11. Marital Status	T	edent Ever in	U.S. 13.	Was Decedent of H		Specify Yes or No-			tates an Indian,
0	ritar	Fun	1 Never Married 2 Married	Armed Fo	2 No No		Was Decedent of H If Yes, specify Cuba	an, Mexican, Puèr	to Rican, etc.)	Blac	k, White,	etc.
5-0036	ral', o	b	3 \ Widowed 4 □ Divorced	If Yes, Gi Year or D			1 ☐ Yes 2 ☑ No	Specify:		Specify	W	hite
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	filed with Hygien that the sint, the	Cor	11				nomemaker			· · · · · · · · · · · · · · · · · · ·	wn Ho	
Maryland	a d d d	Be	17. Father's Name (First, Middle, Last Oscar Lynwood	)					me <i>(First, Middle, N</i> n Elizabet		,	
$\frac{3}{2}$	should be I tod Mental I s marked o umatic ava	은	19a. Informant's Name/Relationship (	Type Print)		10b Mail	nn Address (Street		ural Route Number,			Code
<u>8</u>	₽£5.5		Arthur M. Allen /	туры, Еппі					Mustang,			•
á,	permit. Pages 1 and 3 Department of Health Important: If Itam 27 any injury or other tri		20a. Method of Disposition		20b.		osition (Name of matory or other place		Wilder of the Control	20c. Location -		
altimore,	Pages nent of I int: If Its iry or o		TD Burial 2 ☐ Cremation 3 ☐ 'A ☐ Donation 5 ☐ Other (Special		State		n Cemeter	,	6/05 W	oodlawn	N/-	wal and
≣	artme ortar injur		21. Signature of Funeral Service Lice		, , , , , ,				bbard Fur			
ñ	Depa Impo any ir		) Suit	Sme	- A							and 21229
	Jan Bar		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the dea							Approximate Interval Between
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	/Medical		resulting in death)	Due to	(or as a conse		at the	1410			-	
	Examiner		Sequentially list conditions,	b								
	sit ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as a conse	quence of):						
	and I-tran	хап	that initiated events resulting in death) Last	c	(or as a conse	guence of):						
8760,	icate be executed physician and s the burial-transit		l l		(	4						
-	ficate physics the	edical		_ 0								
Вох	nding use a		IF FEMALE: 23b. Was decedent pregnant		itcome of pregr					23d. Date	e of delive	nry
ň	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Preg	birth 2 □Fe nant at time of		□Ectopic pregnancy □ Other <i>(specify)</i>	/		Mor	ith	Day Year
0	at the death certifi I by the attending I stached for use as	Physician/M	9 Unknown	9□ Unkr	nown							
ς Υ	res that igned b	by P	Part II, Other significant conditions	contributing to o	leath but not re	sufting in the u	inderlying cause giv	en in Part I.	23e. Did tob	acco use contri	bute to th	e cause of death?
ğ	w require been slo should b	ed	Hnorexia						1 ☐ Ye	s 2□No	3 Prob	ably 4.⊞Unknown
S	as be 2 sh	ple	Depression						24a. Was ar	24b. V	Vere autor	psy findings available inpletion of cause of
Ť	The ate h	Completed	•						perform 1  Yes 2	ned? d	eath?	2□ No
/ita	hysician: The taw his certificate has b I director, page 2 s	Be (	25. Was case referred to medical examiner?						ath (Check only one	9)		
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Ň	ding F h. After funera	ion:	27. Manner of Death 1 ■Natural 5 □ Pending		of Injury oth, Day Year)	28b. Time o Injury	Wor		28d. Describe ho	w injury occurre	)d	
<u>s</u>	r Attand er death ractor: by the f	icat	2 Accident investigatio	e 200 Plan	o of Injune - At	homo farm et	M 1 □	Yes 2 □ No	28f. Location (Str	root and Number	R	/ Route Alumber
Division of Vital Records,	lor A after Dirac	Certification;	4 Homicide determined	build	ling, etc. (Spec	ify)	reet, factory, office		City or Town	, State)	i oi muia	r noute rumber,
_	spita sours naral		29a. Certifier 1 Certifying Pl	ysicien: To the	e best of my kr	nowledge, deal	h occurred at the tir	ne, date and place	, and due to the ca	use(s) and mar	nner as st	ated.
	To the Hospital or Attanding Physician: The law requires that the death certif within 24 hours atter death.  To the Funeral Diractor: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only 2 Medical Exer	niner: On the b	pasis of examination of stated.	ation and/or in	vestigation, in my o	pinion, death occu	irred at the time, da	ite and place, a	nd due to	the cause(s)
	To ti withii To ti comp	Ň	29b. Signature and title of certifier				29c. Licens	e number	29	d. Date signed	(Month, I	Day, Year)
	*		Klemen of	Zewli	in, M	n	DYY	377		12/110	2	
	10		30. Name and address of person who	completed cau	se of death (Ite	m 23a) (Type	Print)					
			Dengen Bowlin mo	711 M	aiden	Choi	a Lune,	Cutansv	ille, M	0 213	28	
	Sta Registr		Dengen Bowlin mp  31. Date filed (Month, Day, Year)	005 32	registrar's Sign	nature	and o		,			

TROY MARINE 05-08159 RKD

Amend item#bpest (851,1/12/06 TT Amend item#18, pertH G850,12/16/05 TT State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Troy D. Marine DECEMBER 3, **Physician** 2005 5:30P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SINAI HOSPITAL BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Months | Days | Hours | Min. | (Months | Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 6. Sex 9. Birthplace (State or Foreign 1**M**M 2□ F Months 7-66-694 35 Yrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-1 show traumatic event, the Madical Examinar must be notified at 1 res 2 No Director 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Vas Decedent Evanned Forces?

Yes 2

Yes, Give
Year or Dates: Never Married 2 Married within 72 hours after 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify. 3 Widowed 4 Divorced 15. Decedent's Education fy only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry (0-12) College (1-4or 5+) 18. Mother's Name (Fish, Joe etha 17. Father's Name (First, Middle, Last) To Be den Sumame 2 should be f and Mental h 19b. Mailing Address (Street Number or Rural Route Number, City or Town, State, Zin Code) permit. Pages 1 and 2 Department of Health at important: if item 27 is any injury or other trau 20a. Method of Disposition

Burial 2 Cremation 20b. Place of Disposition (Name of cemetery, crematory or other) 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) (eme 21. Signature of Funeral Service Licensee lin OK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician JUNSHOT +0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit Due to (or as a consequence of) Box 68760. ate has been signed by the attending physicien page 2 should be detached for use as the buria Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2. No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
Yes 2 \[ \] No 24a. Was an this certificate has autopsy performed? Yes of Vital 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 X Yes 2 ☐ No 1X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Certification; Division the Hospitel or Attanding 1 Natural 5 Pending 12:57 AM 1 ☐ Yes 2 X No investigation 45 SUBJECT 2 Accident 3 11ter 3 ☐ Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3264 block W. Belvede 18 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Baltimore, mo outlide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. DECEMBER 4,2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 PENN STREET BALTIMORE MARYLAND 21201 Mil JACK Tith 32. Raistrar's Signature 31. Date filed (Month, Day, Year) State DEC 0 7 2005 Registrar

			For State Registrar	State of Ma	aryland .	,	artment of Hetificate of L			giene Reg. Na2 ()		394	58
2.1	73		Decedent's Name (First, Middle, Last	)	·				2. Date of De Month	ath Day	Year	3. Time of	12
	Physicia /Medic		Carroll Edgar	McCulloh	Jr.				December	05, 2005		9:00	Дм
	Examin	16	4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or		eath	4c. County			
0	Secretary 19		28 Windsor Way	17.4	- // /	A for fresh return of	Roseda 1	e If Under 24 F	Irs R Data of Bir	Bal	timore	ice (State or	r Foreign
	Funeral		5. Social Security Number 6. Se 220–42–6764	X QM 2□F	e (In yrs. Iasi 61	Yrs.	Months Days		rs. 8. Date of Bir Month, Da 08/17/1	944 944	Baltimo	V)	
Apr.	Director		Usual Residence of Decedent		01								
	ehow		10a. State 10b. County		10c. City, T	Town or Lo	cation				100	d. Inside Cit	•
	e Mar	ctor	Maryland Baltim	ore		Rosec	la le					1 🗌 Yes	2X1 NO
	ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of \		ry?	
	ath w	ra	28 Windsor Way	10 W - D 1	F	10	21237	- Origin ?	(Speaty Van er No	United :	States ce - American	n Indian	
	after dea or Items	une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?	No.	13.	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Pu	erto Rican, etc.)	Blac	ck, White, et		
36	urs aff	by F	3 ☐ Widowed 4 ☒ Divorced	1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	1964-19	75	1 ☐ Yes 2 🗓 No	Specify:		Specify	y: Whit	æ	
5-0036	72 hours after death with the Maryland natural: or items 23s or 28s-f ehow deat Examires must be nailfied a	Completed by Funeral Director	15. Decedent's Ed	ucation	1	16a. Dece	dent's Usual Occupa	ition	working	16b. Kind of B	usiness/Indu	ustry	
2	within 7 ene. than "n	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired,	)	norking	Non-Profi	t Owaan	i 72+i0	n
7	filed wi Hygien ther th	S	11 Years			Sa1	es	10 Matheda I	Name (First, Middle			1120110	11
gu	be fill H off	Be	17. Father's Name (First, Middle, Last)	Jak Co							16)		
Maryland	2 should be filed withir and Mental Hygiene. Ie marked other than aumatic event, the M	မှ	Carroll Edgar McCu		7.5	19b Maili	ng Address (Street a		le Marie Co		State, Zip (	Code)	
Z	d 2 s Ith an 27 le		Janette Ritte - Sister				4 Texas Ave		ille, MD 21				
<u>a</u>	ges 1 and 2 should be filled within 72 hours after death with the Maryla it of Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23s or 28s-1 should be not other traumatic event, the Medical Examination must be notified at		20a. Method of Disposition			e of Disor	sition (Name of matory or other place		Date	20c. Location	City or Tow	m, State	
Ë	Pages ent of nt: If it		1 Burial 2 Cremation 3 :		1		vice Corper	1 12	/07/2005	Towson,	MD		
Baltimore,	pernit. Page Dep rtment Imp rtant: Il any injury o		21. Signature of Funeral Service Licen	secharles F.	Miner	_	2. Name and Addres		5305 Ha	rford Roa			
8	Dep Imp		Jan Hing				onard J. Ru		Baltimo	re, MD 21	214		
	Physician /Medical Examiner per partial transit	Examiner	23a. Part1. Enter the disease, or compshock, or learn failure. List only of immediate cuse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.  Due to (or as Due to (or as C.	ine.	nce of):	heme				5	Approximatinterval Bettonset and D	ween Death
.O. Box 68760	death certifica e attending ph of for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	d	2 Fetal de	eath 3	□Ectopic pregnancy			Mo		Day *	Year
s, P	requires that the leen signed by th hould be detache	by P	Part II. Other significant conditions of	ontributing to death I	but not resulti	ing in the u	nderlying cause give	en in Part I.		tobacco use con	tribute to the		death? Unknown
ord	v requir been si should	ted	1) 1A B16	1 (123 )	110 LC	-1-1(18			_	Yes 2 No			
I Rec	The law ate has b page 2 s	Completed	PRR/PE	tente	VASCE	UCA	D 15	12AS FZ	_ 24a. Was auto perf 1 ☐ Yes	ormed?	Were autop prior to com death? 1 Yes 2		available ause of
/ita	iclan: T	Be	25. Was case referred to medical examiner?	Hospital:			oth		Death (Check only				
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uc	ding F h. After funer	i i	1 Natural 5 ☐ Pending	28a. Date of Inj (Month, D.	ay Year)	Injury	Worl	k? Yes 2 □ No	200. 200000	non injury occur			
Division of Vital Records,	I or Attending after death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir	njury - At hom etc. (Specify)	e, farm, st	reet, factory, office		28f. Location City or To	(Street and Num own, State)	ber or Rural	Route Num	ıber,
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical C	29a. Certifier 1/2 Certifying Ph (Check only 2 Medical Examone)	ysician: To the bes niner: On the basis and manner s	of examinatio	edge, dea on and/or in	th occurred at the tin evestigation, in my o	ne, date and p pinion, death o	lace, and due to the occurred at the time	cause(s) and m , date and place,	anner as sta , and due to	ated. the cause(s	s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		-		29c. Licens	e number		29d. Date signe	ed (Month, E	Day, Year)	
	1		Malter 12.	welse		MD	1	120 7	9	DOZC.	5 21	205	
10	0		30. Name and address of person who WALTEN R. L	completed cause of	T mi	7.	Print)	SIEN	Dr. Tu	sson r	nD.	212	-04
State Registrar  31. Date filed (Month, Division of 2005) 7 20052. Registrar's Signature													

State of Maryland / Department of Health and Mental Hygienen 1 - For Stata Registrar Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Thelma M. McIntyre 2, 10:40 December 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

April 3, 1910 13305 Travilah Road Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2ĀF 95 284-01-4671 Yrs Ohio Director Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Maryland Potomac Montgomery 1 ☐ Yes 2 TNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 13305 Travilah Road 20854 United States or Items 23a death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or lean any injury or other traumatic event, the Mudical Exempted ORDE. Black White etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No White Specify: 3 StWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Burkhardt Mary Ann Bower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13305 Travilah Road, Potomac, Maryland M. Kathleen McIntyre/Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State December 6, 2005 Metropolitan Crematory 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Alexandria, Virginia \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service 100092 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Instant Immediate Cause (Final Physician Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any leading among a cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. the a 9 Unknown 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, γ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown page 2 should Completed been Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2**2** No Division of Vital 1 Yes 2 No 1 Yes Hospital or Attending Physician: director 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 2 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie cal (Check only one) within 2 29b. Signature and title of certifier 29c. License numbe. 29d. Date signed (Month, Day, Year) 2 D28656 December 5, 2005 30. Name and audress of person who completed cause of death (Item 23a) (Type, Print) 8609 Second Avenue, Ravi Passi, M.D. Silver Spring, Maryland 20910 31. Date filed (Month, Day, Year) 32. Registra Signature 2005 Registrar

			1 - For State Registrar	State of Maryland /	Department o		Mental Hygier		201.00
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)	lo a l			2. Date of Death	Pay Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Tow	n, or Location of Deat	0)	4c. County of Death	11.19
E	Funeral Director		W1-26 2770	M 2□ F 7. Age (In yrs. last	Yrs. If Under 1 Ye Months Da	ear If Under 24 Hrs lys Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth Court  3. Nort	place (State or Foreign intry)
	Maryland -f show	or	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
	with the halfa or 28a-	Direct	10e. Street and Number		Timore 10f. Zip Coo	le I O	10g. C	Citizen of What Cou	intry?
0036	d within 72 hours after death with the Marylan plane. Jane. Than "natural", or items 23a or 28a-f show than "natural" or items to natified at	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent If Yes, specify 0	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White	
715-00	within 72 hou ene. than "natural he Medical E	Completed b	15. Decedent's Educ (Specify only highest grade Elements y/Secondary (0-12)	cation 16	6a. Decedent's Usual Od (Give kind of work do life. DO NOT use re	one during most of wo	rking 16b.	Kind of Business/tr	ndustry
17 DU	e file othe vent,	Be	17. Father's Name (First, Middle, Last)	F	ORKLITA	18 Mother's Nar	ne (First, Middle, Maide	DAUS  on Sumame)	HIAL
naryıa	2 should be and Mentalie marked	_C	19a. Informant's Name/Relationship (Ty)	ea. Print)	9b. Mailing Address (Str	meet and Number or Ru	ral Route Number, City	okes y or Town, State, Zi	p Code)
ore, ⊾	Pages 1 and 2 should yent of Health and Men int: If Itam 27 ie marke iry or other traumatic		20a. Method of Disposition  1 Burial 2 Cremation 3 R		of Disposition (Name of etery, crematory or other	place)	Date Balfe 20c.	Location - City or T	/ <u>2</u> / <del>8</del> Town, State
Saltim	permit. Page Department of Important: If any injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License	Wes	PERN CEME 221 Name and Ac	thery 12 didress of Facility	10/05 B	alto. A	1D vices
	40 F @ 0		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. De cause on each line.	o not enter the mode of	thorac dying, such as cardiad	d Bulfo or respiratory arrest,	MD 213	Approximate Interval Between
Ng.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Metasta Due to (or as a consequence	tre Pros	tale a	cumon	en	Onset and Death
	Examiner	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence	ce of):				
٥, د	cate be executed oblysician and the burial-transit	i Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	ce of):				
( pg/pf	ertificate to ing physic e as the b	Medical	IF FEMALE:						
.O. Box	the death certifica by the attending phached for use as the	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 ⊟Ectopic pregna			23d. Date of deliv Month	rery Day Year
ras, r	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions con	tributing to death but not resulting	g in the underlying cause	given in Part I.	23e. Did tobacco	o use contribute to t	the cause of death?
Hecord	sician: The law rer certificate has bee irector, page 2 sho	Completed					24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
Vital	Physician: this certifica	Be	25. Was case referred to medical examiner?	omitat		0.1	ath (Check only one)	10 10165	2820
ō	Phy this ald	tion: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/ 28a. Date of Injury (Month, Day Year) 28t	b. Time of 28c. I	Other: 4 Nursing H njury at Work? 1 Yes 2 No	ome 5 Residence 28d. Describe how in	6 ☐ Other (Speci jury occurred	fy)
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	, farm, street, factory, off	ice	28f. Location (Street City or Town, Sta		al Route Number,
	ha Hospit n 24 hours ha Funera bletely fille	edical (	29a. Certifier 1 Certifying Phys (Check only 2 Medical Exemin	cician: To the best of my knowled her: On the basis of examination and manner stated.	dge, death occurred at the and/or investigation, in n	e time, date and place ny opinion, death occu	, and due to the causer rred at the time, date a	(s) and manner as s ind place, and due t	stated. to the cause(s)
	Tot withi Totl	M	29b. Signature and title of certifier	mpleted cause of death (Item 23:	29c. Lic	ense number 020396	29d. [	Pate signed (Month,	Day, Year)  5, 2005
	3		30. Name and address of person who for DG VIS M Her	mpleted cause of death (Item 23:	a) (Type, Print) Rave	a Blud	Be Hi	md 2	1239
	Sta Registr		31. Date filed (Month, Day, Year) DEC 0 7	2005 Registrar's Signature	B. Aparle				

State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Reg No Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) November 30, 2005 **Physician** 11:50 PM Joseph Ignatius Napoli /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, ) April 17, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Hours Months 1⊠M 2□ F 1925 Washington, D.C. 80 Yrs. 579-22-5169 Director Usual Residence of Decedent a filed within 72 hours after death with the Maryland if Hygiene.
other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County rai", or items 23a or 28a-f show Examiner must be nutified at 1X Yes 2 □ No Rockville Maryland Montgomery Direct 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number United States 20851 1208 Brooke Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. XYes 2 ☐ No f Yes, Give 1 Never Married 2 N Married 10 Baltimore, Maryland 21215-0036 1 Yes 2K No Specify. Specify: If Yes, Give Year or Dates: WW II White þ 3 \( \text{Widowed} \) 4 \( \text{Divorced} \) the Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Flementary/Secondary (0-12) Auto Parts Store Delivery Driver 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked othe any injury or other traumatic event, soice. 17. Father's Name (First, Middle, Last) Mary Amato Settimo Napoli 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19325 Treadway Road, Brookeville, Maryland 20833 Margo L. Cook/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State December 3. 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bethesda, Maryland 2005 Crematoriúm, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, In 300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service Licensee M00198 23a. Part1. Ento the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) > day **Physician** Septic Shock /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No the be detached Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Dementia peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed 2X No 1 Yes certificate Division of Vital Attending Physician: neral Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Inpatient 2 ☐ ER/Outpatient 3 DOA ဥ 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the to 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Phy STRIAN D0063088 December 1, 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Maryland Mohit Rastogi, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DEC 0 7 2005

ithe JA(K State

Mil)

December 03, 2005

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

O.C.M.E.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 5 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 02:30a <sup>M</sup> DECEMBER 6, ETHEL 2005 PATTERSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) GILCREST HOSPICE CENTER 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🔀 F Yrs Director 249-38-2032 SOUTH CAROLINA August 15,1926 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count ral', or Items 23a or 28a-f ehow Examiner i, ust be notified at 1√ Yes 2 No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1731 N. ELLAMONT ST 21216 U.S.A filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: þ er than "natural", 3 ☑ Widowed 4 □ Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th DOMESTIC HOUSE CARE 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fit Department of Health and Mental Hy Important: If item 27 is marked oth eny julyy or other traumatic event 2008. 17. Father's Name (First, Middle, Last) CHARLES CAIN IDA MAE CANTY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1018 N. WOODINGTON RD Baltimore, MD 21229 VONDA LEIGHTON/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12-9-2005 BALTIMORE, MD KING MEM. PARK 21. Signature of Funeral Service Licensee Wm. C. Brown Comm F/H P.A. 1206 W. North Ave. Baltimore, MD 21217 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Part1. Enter the disease, or coshock, or heart failure. List of Inmediate Cause (Final disease or condition resulting in death) Physician Live mintan cancer /Medical Due to (or all a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 PNo 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 A No 2 1 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOSPice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ္ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) After the funeral of 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medic 29c. License number 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) D 58303 December 6 2005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AAAIN CHALLES, MD 601 N. CLALS ST TOUSON, MD 21204 Day, Year)
DEC 0 7 2005

32. Restrar's Signature & 31. Date filed (Month, Day, Year) State Registrar

			1 - For State Registrar	State of Mary	•	artment of		nd Mental	Hygien	2005	39464
	Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date Mont	of Death	ay Year	3. Time of Death
	/Medic Examin		Eugenia D. Pierso  4a. Facility Name (If not institution, give s			4b. City, Town,	or Location of	Decei		c. County of Dea	10:25 AM M
			Fairhaven Retire			Sykesv				Carroll	
	Funeral Director		5. Social Security Number 6. Sex 148–16–0705	11. aCle	yrs. last birthday)  7 Yrs.	Months Days		Min (Mont	of Birth h. Day, Year 1, 19	r) Co	thplace (State or Foreign ountry) Jersey_
	land bw		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	ocation					10d. Inside City Limits
	Mary B-f sh	itor	MD Carrol1		Sykes	ville					1 ☐ Yes 2 ☐ No
	vith the	Funeral Director	10e. Street and Number	o Cottago (	7	10f. Zip Code	21784		10g. C	itizen of What Co	ountry?
	leath v	eral	7200 Third Avenu	12. Was Decedent Eve		Was Decedent of		n? (Specify Yes	or No-	USA 14. Race - Ame	erican Indian,
39	filed within 72 hours after death with the Maryland Hygione. the than "natural", or tlems 23a or 28a-f show ant, the Medical Evanit er must be notified at	þ	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give  Year or Dates:	- 1	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No		Puèrto Rican, etc	5.)	Black, White	white
2-0	72 hou natura	eted	15. Decedent's Edu		(Give	dent's Usual Occu	e during most o	f working	16b.	Kind of Business	Vindustry
Maryland 21215-0036	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 5+		DO NOT use retir Lousewife	•	-		7	
ک 2	a filed il Hygi other vent, I	Be Co	17. Father's Name (First, Middle, Last)			ousewire		s Name (First, M		OWD home on Surname)	2
ylar	Menta Menta Marked	ToE	Roland Hasbrouck					ne Adele			
Mar	d 2 sh th and th and 17 ls m traum		19a. Informant's Name/Relationship (Ty) Kenneth Pierson/s			ng Address (Stree					
altimore,	ges 1 and of Heal		20a. Method of Disposition  1 Burial 2 Cremation 3 R	2	20b. Place of Dispo	Third Average of the plant of t		Date 2		esville, Location - City or	MD 21784 Town, State
Baltim	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a f show amy intery or other traumatic event, the Medical Executive mast be notified at ances.		21. Signature of Foneral Service License Ronald Service Williams	ade, projec		Name and Add			W. Ba	 ltimore	Street
	40380		E3a. Part1 Enter the disease, for complishock or heart failure. List only or	cations that caused the		ltimore, er the mode of dy		1201 urdiac or respirat	ory arrest,		Approximate
	Physician /Medical		shock or heart failure. List only or Immediate Gause (Final disease or condition resulting in death)	Small Cel	11 lung (						Interval Between Onset and Death
	Examiner		Sequentially list conditions	Due to (or as a co	onsequence <del>-o</del> r):						
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a co	onsequence of):						
	execution and sal-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
8760,	cate be executed physician and the burial-transit	dlcal	C.	l							
Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the builal-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p	Fetal death 3	Ectopic pregnan	су			23d. Date of de Month	livery Day Year
o.	the de	hysic	1 Yes 2 No 9 Unknown	4 Pregnant at time 9 Unknown	e or deaut 5	Other (specify)					
rds, P	w requires that been signed to should be det	by	Part II. Other significant conditions con	stributing to death but no	ot resulting in the u	nderlying cause g	iven in Part I.		Did tobacco		o the cause of death?
Division of Vital Records,	ician: The law re certificate has bee rector, page 2 sho	Completed						_	Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
ita	ian: ortifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Place o	f Death (Check	-	0 101165	2 1 10
<u>ح</u> <	Physic this ce al dire	은	1 □ Yes 2 No	lospital:	2 ER/Outpatien	IL SLI DOA			<u> </u>	6 □Other (Spe	ocify)
ono	Attending Physician: r death. ector: After this certifici by the tuneral director,	tlon	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of Injury	W	uryat ork? ⊒Yes 2.⊟No		ribe now inji	ury occurred	
Divisi	l or Atten atter deal Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	At home, farm, str Specify)	eet, factory, office	)		ion (Street a or Town, Stat		ural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the tuneral director, page	edical C	29a. Certifier (Check only one)  Check only one)  Certifying Physical Exemination (Check only one)	sician: To the best of m ner: On the basis of exa and manner stated	amination and/or in	occurred at the vestigation, in my	time, date and popinion, death	place, and due to occurred at the	the cause(: time, date ar	s) and manner as nd place, and due	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	Da wa			nse number		29d. D	ate signed (Mont	th, Day, Year)
			I Cur Jan	the min	•	Dops	40)4		12	1,10,	
			30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type,	etireme	ent (	omm	1		
	Sta Registr		31. Date filed (Month, Day, Year)  DFC 0 7 2005	32. Registrar's	Signature	the same			1		

		Please Type or Print in Black In State of Maryland / Dep		_	200
		1 - State Registrar Ce	rtificate of Death	Rag.	CUUD 37400
Physi /Med		1. Decedent's Name (First, Middle, Last)  Margaret Elizabeth Pierpont		2. Date of Death Month December: 3	2005 Year 7:57 P M
Exam		4a. Facility Name (If not institution, give street and number)  10 W Elm Avenue	4b. City, Town, or Location of Death Baltimore County	n	4c. County of Death Baltimore
Funera	_	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day Ye) June 4 1910	9 Birtholace (State or Foreign
Directo	r	Usual Residence of Decedent		June 4 1910	
Maryla a-f sho	tor	Maryland Baltimore Baltimore Baltimore			10d. Inside City Limits 1 ☐ Yes 2 📉 No
with the	Funeral Director	10e. Street and Number	10f. Zip Code 21206	10g. US	Citizen of What Country?
r death	Inera	10 W Elm Avenue  11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert		14. Race - American Indian, Black, White, etc.
5-UU36 72 hours after death with the Maryland natural', or Items 23g or 28a-1 show alsal Exportment Public Indifficed at	þ		1 ☐ Yes 2 ☐ No Specify:	,,	Specify: White
ING 21213-UU36  be filed within 72 hours after death with the Marylan tal Hygiene. Id other then "naturel", or Items 23s. or 28a-1 show event, It a Markled Extrating must be notified at	Completed		dent's Usual Occupation a kind of work done during most of wor DO NOT use retired)	rking 16b	. Kind of Business/Industry
C 2121 filed within Hygiene. whar than "	Com	12 College (1-40r 5+) House	keeping & Dining Room		ryland School for the Bli
	To Be	17. Father's Name (First, Middle, Last) George L Klink		ne (First, Middle, Maid K. Moseman	(en Sumame)
re, Maryla s 1 and 2 should f Health and Men itam 27 is marka other traumatic.			ng Address (Street and Number or Ru Old Road Bayfront I	ral Route Number, Cit Baltimore, Mar	y or Town, State, Zip Code) vland 21219
	2	20a. Method of Disposition 20b. Place of Disposition cemetery, cre-	osition (Name of matory or other place)	Date 20c	Location - City or Town, State
Baltimore, permit. Pages 1 a Department of Hea Important: If item any injury or othe	á	'4 □Donation 5 □Other (Specify)	i		ltimore,Maryland
n e e e e e		23a. Parti. Enter the disease, or complications that caused he death. Do not en	2. Name and Address of Facility Lassahn Funeral Home 1 7401 Belair Road Balti		nd 21236
Physiciar		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
/Medica Examine	ı	resulting in death)  a. Due to (or as a consequence of):	, 011		
pe tis	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
<b>5U,</b> be executed ician and burial-transit	Examiner	Cause (Disease of Injury that initiated events resulting in death) Last   C			
<b>68 / 6U</b> ilicate be e g physician as the buria	dicai	d			
death cert e attendin d for use	Physician/Medi	1 Yes 2 No 4 Pregnant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ecords, F.O. law requires that the as been signed by thi 2 should be detache	by Phy	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	o use contribute to the cause of death?
require		HYPERTENSION		1 □ Yes	2 No 3 Probably
The lar	Completed	DEITYDEATION		24a. Was an autopsy performed	
d is	To Be	25. Was case referred to medical examiner?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)  Hospital: 1 \( \subseteq \text{Inpatient} \) 2 \( \subseteq \text{ER/Outpatier} \)	Other	th (Check only one) ome 5 Residence	6 ☐ Other (Specify)
ing when		27. Manner of Death  Natural 5 Pending (Month, Day Year)  28b. Time of Injury  28c. Date of Injury  (Month, Day Year)  28b. Time of Injury		28d. Describe how in	
DIVISION No Hospitel or Attanding 1.24 hours after death. The Funeral Director: After letely filled in by the funer	Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, str building, etc. (Specify)		28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Hospitel or At 24 hours after of Funeral Dirac etely filled in by	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deatled to the pasts of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occur	and due to the cause rred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the I within 2. To the complet	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
Q /	2	30. Name and address of person who completed cause of death (Item 23a) (Type,	D0058457	DEC	EMBER 6 2005
U	tata	NAVA CEASAL E2 NRTH  31. Date filed (Month, Day, Year)  32. Registrar's Signature	EVIAN STREET	BATTIM	ORE MD 21201
Regis	- 1	DEC 0 7 2005 Been & A	rester		
DHMH 17 Rev 1	/2001	Latina in the	300 0 0 T		

			For State Registrar	State of Mary	land / Depa <i>Cei</i>	irtment of tificate of	Health a f <i>Death</i>		gienen 0 E	39466
			1. Decedent's Name (First, Middle, Last	")				2. Date of De Month		3. Time of Death
	Physicia /Medic		Sherry Wyatt P	etrarca				Decembe		n u
	Examin		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of	Death	4c. County of	Death
			7509 Royal Domin			Bethe			Montgo	
	Funeral Director	i i	2/8-56-3263	x 7. Age (li	n yrs. last birthday) 50 Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Date of July 13	y, Year)	9. Birthplace (State or Foreign Country) Ohio
	and w		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	cation				10d. Inside City Limits
	Aaryli f sho	ō			Bethesda					1 ☐ Yes 2 ☒ No
	the tage	Director	Maryland   Montgome 1  10e. Street and Number	- y	betnesda	10f. Zip Code			10g. Citizen of Wh	at Country?
	With 3a or	0	7509 Royal Domini	on Drive		20	817		United S	tates
	ns 2:	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13. )	Vas Decedent of	Hispanic Orig	in? (Specify Yes or No	- 14. Race -	American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other treumstic event, I've Modical Examiner must be notified at once.		1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		r Yes, specify Cu □ Yes 2⊠ No		Puerto Rican, etc.)		White etc. White
21215-0036	2 hou	Completed by	15. Decedent's Ed	ucation	16a. Deced	lent's Usual Occi	upation		16b. Kind of Busi	ness/Industry
215	hin 7.	ple	(Specify only highest grad	College (1-4or 5+)	life. I	kind of work done OO NOT use retir	e during most red)	or working		
2	d wit giene er the	Com	213.113.114.17, 35551.14.17	2	Resta	urant Ma				ood service
p	al Hy 1 oth	Be (	17. Father's Name (First, Middle, Last)					's Name (First, Middle	, Maiden Sumame)	
Maryland	Ment Ment arked aric e	2	Harry Ray Wyatt					a Hurst		
lar	and and is my		19a. Informant's Name/Relationship (7					r or Rural Route Numb		
2,	and ealth m 27 her tr		Carmine N. Petrar			the second second	minion	Drive, Bet		aryland 20817
Ore	ges 1 t of H if Ite or otl		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □	Removal from State		natory or other pl	De	ecember 7,	20c. Location - C	
Ē	tmen tent: jury		* 4 ☐ Donation 5 ☐ SOther (Specify		Gate of F			2005	Silver S	ring, Maryland
Baltimore,	permit Depar Impor any in		21. Signature of Funeral Service Licent	-	Be 1356 Be	thesda-(	Chevy ( Maryla	Chase, Inc. and 20814-3	7557 W:	Funeral Home/ isconsin Avenu
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the	e death. Do not ent	er the mode of dy	ying, such as o	cardiac or respiratory a	rrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Breast	Cancer					Onset and Death  3 Years
	/Medical		resulting in death)	Due to (or as a c						37 10010
8	Examiner		Sequentially list conditions,	b						
	p #	Examiner	cause. Enter Underlying	Due to (or as a c	onsequence of):					
	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	oneoguange of):					
8760,	icate be executed physician and s the burial-transit			Due to (or as a c	orisequence or).					6
87	physi the t	dlc		d						
9 x	death certificate be executed e attending physician and nd for use as the burial-transit	hysician/Medical	IF FEMALE:	23c. If yes, outcome of p	pregnancy				23d. Date	of delivery
Вох	atten for u	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnan Other (specify)	ncy		Month	
o.		ıysi	1 ☐ Yes 2 🛣No 9 ☐ Unknown	9□ Unknown						
۵.	requires that the een signed by th hould be detach	by P	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the u	nderlying cause g	given in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
rds	quire n sign							1□	Yes 2⊠No 3	☐ Probably 4 ☐ Unknown
Vital Records,	≥ □ □	ompleted						24a. Was	an 24b. We	ere autopsy findings available
Re	The lay	mo							rmed? dea	or to completion of cause of ath? ☐ Yes 2☐ No
tal		C	25. Was case referred to medical				26. Place	of Death (Check only		2 2 10
<u> </u>	Physicien: this certific ral director,	OB	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1   Inpatient	2 ER/Outpatier	t 3 DOA	)thor	rsing Home 51 Resi		(Specify)
10		n; T	27. Manner of Death	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	28c. Inj	jury at fork?	28d. Describe	how injury occurred	
jo	를 곧 중 글	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		,,		□Yes 2□N	No		
Division	or Attendate death	ertification;	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (	- At home, farm, str Specify)	eet, factory, office	е	28f. Location ( City or To	Street and Number wn, State)	or Rural Route Number,
٥	spital or A ours after nerel Dire	O						ly	<u> </u>	
	Ho H h Fur Tely	edical	29a. Certifier 1	ysician: To the best of n liner: On the basis of ex and manner stated	amination and/or in	n occurred at the vestigation, in my	time, date and opinion, deat	d place, and due to the h occurred at the time,	cause(s) and mann date and place, and	ner as stated. d due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	-	$\overline{}$		nse number		29d. Date signed (	Month, Day, Year)
)	1	1	1 Jun 8	~ ( )	148 W	D430	83		December	5, 2005
1	5		30. Name and address of person who deerge A. Sotos, I				rive.#3	00. Rockvi	lle. Mary	rland 20850
	Sta Regist			32. Registrar's	0:	*		o, RockvI	LLC, Haly	20030
	negisti	(All	55001	- VV						

			For St  1 - State Registrar	ate of Maryland		artment of H		nd Men	tal Hygie	4000	39467
4	Physicia		1. Decedent's Name (First, Middle, Last)  Richard L. Reed						Date of Death Month		3. Time of Death 7:40 A. M
	/Medic Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, o	r Location of [		Cember	4c. County of	
			Gilchrist Hospice (	Center			owson			Baltir	
E.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	Months Days	If Under 24 Hours		Date of Birth Month, Day, Ye		Birthplace (State or Foreign Country)
	Director		213-30-5155 Usual Residence of Decedent	72					7/7/19	133 1	Maryland
	nylanc how		10a. State 10b. County	10c. City, T	own or Lo						10d. Inside City Limits
	Ba-f e	Director	MD Baltimore			Catonsv	ille				1 Tes 2 No
	with the	Dire	10e. Street and Number			10f. Zip Code	0.0		10g.	Citizen of Wha	
	heath me 23	Funeral	1 University Avenue	Vas Decedent Ever in U.S.	13. \	212 Was Decedent of H f Yes, specify Cuba		n? (Specify	Yes or No-		American Indian,
٥	after o		1 Never Married 2 Married 1	rmed Forces?	+	f Yes, specify Cuba 1 □ Yes 2 <b>2</b> No	an, Mexican, F Specify:	Puerto Rica	n, etc.)		White, etc.
200	ural',	d by	3 ☐ Widowed 4 ☑ Divorced Y	'ear or Dates:						Specify:	White
9212-9039	filed within 72 hours after death with the Maryland Hygiene. other than "natural; or Itame 23a or 28a-f ehow ent, the Madical Examination notified at	Completed	15. Decedent's Education (Specify only highest grade con	npleted)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most o	of working	168	o. Kind of Busin	ness/Industry
717	withi	ошо	Elementary/Secondary (0-12) C	college (1-4or 5+)		olice Off			La	w Enfo	rcement
	be filed with tal Hygiene od other the event, the	BeC	17. Father's Name (First, Middle, Last)					s Name (Fir	st, Middle, Mai		
<u>a</u>		ToE	Richard Biniak						Muller		
Maryland	2 6 - 5	1 2	19a. Informant's Name/Relationship (Type, F Richard Biniak Jr.			g Address (Street				-	
	1 an Heal Heal Ther		20a, Method of Disposition			sition (Name of natory or other place		Date			ty or Town, State
פֿב	Pages nent of I nnt: If Its ury or o		1 ☐ 8urial 2 ☑ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	Valificiti State		natory or other plac ematory		2/6/20		tonsvil	
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licenses	Y 0	22	. Name and Addre	ss of Facility	Witzk	e Funer	al Home	e of Catons-
è	40384	$\Box$	23a Part 1 Enter the disease or complication	ins that caused the death.							tonsville, MD
	Physician /Medical		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call immediate Cause (Final disease or condition resulting in death)	Use on each line.  Lywholish  Due to (or as a consequent	neli f	iratre	disor	der			Interval Between Onset and Death
	Examiner			Due to (or as a consequer	017.						
	2 7 × 1	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequer	ica uf).						
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	-00 of):						
760,	ate be executed hysicien and the burial-transit	cal E		Due to (or as a consequer	ice oi).						
687	ficate p phys s the		d								
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	in the past 12 months?	f yes, outcome of pregnancy □Live birth 2 □ Fetal de □ Pregnant at time of deat □ Unknown	ath 3	Ectopic pregnancy Other (specify)	′			23d. Date o Month	of delivery Day Year
۵.	res that the igned by be detact		Part II. Other significant conditions contribu	iting to death but not resulting	ng in the u	nderlying cause giv	en in Part I.	T	23e. Did tobac	co use contribu	ite to the cause of death?
ds	urires n sign	d by							1 🗌 Yes	2 No 3[	Probably 4 Unknown
Records,	The law require ate has been sli page 2 should t	Completed							24a. Was an autopsy performed	prio dea	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
Division of Vital		Be C	25. Was case referred to medical examiner?		esta line e		26. Place	100	eck only one)	,140	103 22 10
<u>&gt;</u>	d s	To	1 ☐ Yes 2 ☐ No Hospi	1 Unpatient 2 EF	/Outpatier		4 🗆 Nurs		5 🗌 Residenc		(Specity) No spile
U C	Jing Pt. J. After th funeral	on:	i somaturar 5 1 ording	Ba. Date of Injury 28 (Month, Day Year)	lb. Time of Injury	Wor			Describe how	injury occurred	`
Si	death death stor: the	icat	2 Accident investigation 3 Suicide 6 Could not be	Be. Place of Injury - At home	a farm str		Yes 2 □ No		ocation (Stree	at and Number	or Rural Route Number,
<u> </u>	after after I Direct	Certification:	4 Homicide determined	building, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	oot, radiory, onloo			City or Town, S		
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in its	Medical C	(Check only 2 Medical Exeminer:	n: To the best of my knowle On the basis of examination and manner stated.	dge, death and/or in	n occurred at the tir vestigation, in my o	me, date and opinion, death	place, and o	due to the caus t the time, date	e(s) and manne and place, and	er as stated. I due to the cause(s)
	ro the	Med	29b. Signature and title of certifier	and marrier states.		29c. Licens			29d.	Date signed (A	Month, Day, Year)
	- > F 0		1 Olrano	ws		DZ	8300	)	D	ecembe	er 2 2005
ĺ	6+1		30. Name and address of person who comple	eted cause of death (Item 2)	Sa) (Type,		SWBUN	M	2/204	1	
3	Sta Registi		31. Date filed (Month, Day, Year) DEC 0 7 2:005	32. Registrar's Signatur	9	V.					
			DEG 0 1 6000	STREET AT	12846						

DHMH 17 Rev 1/2001

12/2/05

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State o	of Marylar		artment of F		and Mental F	lygien Reg:N	100 May 17-140	201.68
			Decedent's Name (First, Middle,	Last)					2. Date of Month	Death -	<del>. U U U</del>	3. Time of Death
	Physicia /Medic		John M. Ruta						Decem		ay Year 5, 2005	6:30 P M
	Examin		4a. Facility Name (If not institution,	•	*	_	4b. City, Town, o			4	c. County of Death	
			Future Care Heal 5. Social Security Number 6	th Cente	7. Age (In yrs.		Balt If Under 1 Year	imore		Rieth	Q Rieth	place (State or Foreign
	Funeral Director		218 26 2275	1.39X 1.37M 2. F	74	Yrs.	Months Days	Hours	Min. 8. Date of (Month,	Day, Year	r) Cou	place (State or Foreign ntry) vland
			Usual Residence of Decedent						<u> </u>	, 100		
	arylan show	_	10a. State 10b. County			ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	ecto	Maryland Baltin  10e. Street and Number	ore	M	iiddle	River 10f. Zip Code			10g C	itizen of What Cou	
	or death with the Marylan tems 23a or 28e-f show erroust be notified at	Funeral Director	2166 Firethorn F	d.			2122	20		109.0	USA	
	ter death Items 23	nera	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Decedent of H	lispanic Ori	gin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - Ameri Black, White,	
98	72 hours after death with the Maryland Insturat; or Items 23s or 28s-f show Alcal Exacilist Francist Le redificat at	y Fu	1 Never Married 2 Marrie	d 1 XYes	2 □ No ive Dates: 1953,		1 ☐ Yes 2 🔀 No	Specify:			Specify: Wh:	
ő	hours tural,	ed by	3 Widowed 4 Divorced		Dates: 1999	, ,	dent's Usual Occup	nation		16b	Kind of Business/Ir	ndustry
15	in 72 n "na Nedic	Completed	(Specify only highest Elementary/Secondary (0·12)	grade completed)	) (1-4or 5+)	(Give	kind of work done DO NOT use retired	during mos d)	t of working	100.		
212	giene giene er tha	mo.	10	College	1-401 34)		Fabricato				bber Indu	stry
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, La	ast)					er's Name (First, Mide	dle, Maide	en Sumame)	
ryla	hould d Mer narke natic	<sup>2</sup>	Guiseppe Ruta  19a. Informant's Name/Relationshi	n (Type Print)		19h Mailir	ng Address /Street		Mangini er or Rural Route Nui	nher City	or Town State Zi	n Code)
Ma	id 2 sl Ith an 27 Is r treur		Rebecca Ruta (Wi						Baltimore			, code)
ē,	s 1 ar if Hea item other		20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·		Place of Dispo	sition (Name of natory or other place		Date		Location - City or T	own, State
Ë	Page nent o ant: If ury or		1 ØBurial 2 ☐ Cremation 3 1  Other (Specific Specific	State Mar	yland	Veterans	Cem. 1	12/9/2005	Cro	wnsville,	Maryland	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Bellingortent: If item 27 is marked other than "natural; or it any injury or other traumatic avent, I'ra Medical Erarilli Once.		21. Signatura of Foreral Surfect.	Con 500	2	B B	Name and Addre	ss of Facilit	<sub>ty</sub> neral Home	P.A.		
	70 = 6 Q	$\subseteq$	22 Part Empreto disease or o	omplications that	caused the deat	th. Do not ent	407 Old I	Easter	cardiac or respirator	Essez	x, Md. 21	221 Approximate
	Ob		20a. Part1. Experitte disease, or c shock, of heart failure. List o Immediate Cause (Final	nly one cause on						,		Interval Between Onset and Death
	Physician /Medical		disease of condition resulting in death)	aDue to	(or as a consec	quence of):	y arter	7 11	15.47V2			Underun
	Examiner		Securitally list conditions	b								
	ed sit	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consec	quence of):						
	be executed sician and burial-transit	Examin	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):						
8760,	cate be executed physician and the burial-transi	dical		d								
		Medi	IF FEMALE:									
Вох	Attending Physician: The law requires that the death certifi refath. rdeath. sctor: After this certificate has been signed by the attending sy the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 Feta	al death 3[	Ectopic pregnancy	У		Ì	23d. Date of deliv Month	ery Day Year
P.O.	to the de tached tached to	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unkr	nant at time of one	geam 5	Other (specify) _					
σ,	s that ned b	by Pt	Part II. Other significant condition	s contributing to	death but not res			en in Part I	. 23e. D	d tobacco	use contribute to t	he cause of death?
rds	w requires been sign should be	ed t	n	of Stac	o plus	a au	sluse		1	Yes :	2 □No 3 □ Pro	bably 4 Honknown
Records,	law re las be	Completed	/	hence					24a. W	itopsv	/ prior to co	opsy findings available ompletion of cause of
E B	: The lav		<u> </u>						1 □ Ye			2 No
Vital	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	TED/Outpoties	nt 3□ DOA Oth		of Death (Check on		c Clother (Cree	4.1
of	g Phys er this eral di	$\vdash$	27. Manner of Death	28a. Date		28b. Time o			ursing Home 5 🗆 R 28d. Descril		jury occurred	ly)
ion	death. ctor: After y the funera	atio	1 Natural 5 Pending 2 Accident investiga	ition	min, Day 16ar)	injury		Yes 2	No			
Division of	or Atterder de Directon by ti	Certification;	3 Suicide 6 Could no 4 Homicide determin	289. Plac	e of Injury - At h ding, etc. (Speci	nome, farm, st ify)	reet, factory, office		28f. Locatio City or	n (Street a Town, Sta	and Number or Run ite)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a, Certifier 1 Certifying	Physician: To th	ne best of my kni	owledge, deat	h occurred at the ti	me, date an	nd place, and due to t	he cause/	(s) and manner as	stated.
	ne Hos ne Fur netely	Medicai		xaminer: On the					ath occurred at the tin			
	To the Comp	Ž	29b. Signature and title of certifier	Ha	. ^		29c. Licens		7 /	29d. D	ate signed (Month,	Day, Year)
	, A =		1	/ W	47		/)	275	69	_ (	VIVIUS	
9	747	1	30. Name and address of sers, w	no completed cau	use of death (Ite		Print) GY	line	True	91	1103	>
	Sta	ite	31. Date filed (Month, Day, Year)	-	Registrar's Sign		to Second	-CFC	1,0-0	•		
	Regist		DF	C 0 7 200	5 kg	2.00	& Social	9				

ORIGINAL

12-5-51

Ruta, John matthew

			1 - For State Registrar	State of M	1aryland				ealth a Death	and M	-	giene Reg. Né.	00	5	394	69
ź	Physic	an	1. Decedent's Name (First, Middle, La	·							2. Date of De. Month Decemb	ath Day	20,8	(ear	3. Time of	
10	/Medi	cal	Edward Guy Russ  4a. Facility Name (If not institution, giv				4h Cih	Tour	Location o	l Daath	Decemb				2:10	) au
*	Examir	ner	2 Right Wing Driv		'/				River				County of altin			
	Funeral	-	Social Security Number 6. 8	ex 7. A	ge (In yrs. ia	ast birthday)	If Unde	r 1 Year	If Under 2	24 Hrs.	8. Date of Birt			). Birthol	ace (State o	r Foreign
1.75	Director		220-01-1100	M 2□F	9:	2 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day July 1	3,19	13 V	7irg	înia	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City.	, Town or Lo	cation							10	d. Inside Cit	be Limite
	Maryl f sho	Ď	Maryland Baltimor	e		Middle		er							1 🗆 Yes	
	r 28a	Director	10e. Street and Number				10f. Zi	o Code				10g. Citiz	en of Wh	at Count	ry?	
	th witi		2 Right Wing Drive	2			2	1220				U.S	S.A.		,	
	ems erms	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S		Was Dece	dent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	. 1	4. Race -	America White, e		
36	s afte	by Fi	1 ☐ Never Married 2 ☐ Married  XXWidowed 4 ☐ Divorced	1 Tes 2 If Yes, Give			1□ Yes		Specify:		, , , , , ,		Specify:			
8	within 72 hours after death with the Maryland one. than "natural" or items 23a or 28a-f show the Madical Examinat must be notified at		15. Decedent's E	Year or Dates		16a. Deced	dent's Usu	al Occupa	ition			16h Kin	d of Busir	Wh:		
215	hin 72 In "n Media	piet	(Specify only highest gra Elementary/Secondary (0-12)		541	(Give	kind of we	ork done d ise retired,	uring most	of worki	ng	100. 1	0 000	1033/11/01	usity	
21	filed wit Hygiene other tha	Completed	10	0011090 (1 401	347	Carp	ente	r				Cons	struc	ction	1	
Ind	be file	Be	17. Father's Name (First, Middle, Last,								(First, Middle,		,			
$\frac{2}{5}$	2 should be and Mental is marked of aumatic even	유	Robert Lee Russell								rginia 1					
Maryland 21215-0036	d 2 sl th and t7 is r traur		19a. Informant's Name/Relationship ( Edward L. Russell								<i>I R</i> ou <i>te Numbe</i> Baltimo:				,	1
ē,	ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If itam 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ita Madical Examinat must be notified at		20a. Method of Disposition			ace of Dispo	sition (Na	me of			ate		ation - Cit			
Ë	Page nent o nnt: If		1 X urial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		9	metery, cren ly hil			· 1	ec.8	,2005	Balt:	imore	. Ma	arylan	ď
Baltimore,	permit. Pages 1 and Department of Healt Importent: If Item 2 any injury or other ange.		21. Signature of Funeral Service Licer	S88					L		Funera			•		
<u> </u>	89789	(	12				407	ora F	aster	cn Ay	venue, .	LSSe:	x, Ma	ryla	and 21	221
	Physician /Medical		23a. Part Ther the disease, or com shopk, or heart lailure. List only Immediate Cause (Final disease er-condition resulting in death)	one cause on each	od the death. line.	OKE		de of dying	, such as o	cardiac o	r respiratory ari	rest,		1	Approximate Interval Betw Onset and D	veen
8760,	mineral be executed by executed by sician and burial-transit sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	DE s a conseque s a conseque		2714	4								
P.O. Box 68	Attending Physicien: The law requires that the death certifica rideath. r death. ector: Atler this certificate has been signed by the attending phet the funeral director, page 2 should be detached for use as the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal o	death 3	Ectopic p					23	3d. Date o Month			ear ear
	s that gned b	by Pi	Part fl. Other significant conditions of	ontnbuting to death	but not result	ting in the un	nderlying o	ause give	n in Part I.		23e. Did to	bacco us	e contribu	te to the	cause ol de	ath?
ğ	en sig	ted t								_	1 🗆 Y	es 2/	No 3[	] Probal	oly 4 🗆 U	nknown
ecc	e law re has be	Completed									24a. Was a autops				sy findings a	
<u> </u>	The page	Con									perfor	med?	dea	th?	oletion of ca ¶√No	U 20 OI
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hogostali.				i -		of Death	(Check only or	10)			1	
ō	Phys this ral dir	. To	1 Yes 2 No	Hospital: 1 ☐ Inpati 28a. Date of Inj	ent 2 E	R/Outpatient			4   Nur		ne 5 Reside			Specify)		
on	ding h	tlon	1/Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Injury	M	28c. Injury Work'	at ? es 2⊡N		8d. Describe h	ow injury	occurred			
Division of Vital Records,	를 를 들	Certification:	3 Suicide 6 Could not be determined	28e. Place of In	jury - At hom tc. (Specify)	ne, farm, stre					8f. Location (Si City or Town	treet and n, State)	Number o	or Rural I	Route Numb	Ө <i>г</i> ,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edicai	one)	ysician: To the best liner: On the basis of and manner s	of examination	on and/or inv	estigation	, in my opi	nion, death	J OCCULLE	d at the time, d	ate and p	lace, and	due to ti	ed. ne cause(s)	
	To To	Σ	29b. Signature and title of certifier	, , ,	n		290	. License	number	0	2	9d. Date	signed (N	fonth, Da		
		)	Man Tous	roll .	12	)	7	770	200	5		12	16	10	5	
	0		30. Name and address of person who	completed cause of	death (ftem 2	23a) (Type, f	Print)	e	RA.	, 7, 4	YARE	H	Ω	217	137	•
	Sta		31. Date liled (Month, Day, Year)	completed cause of a 22. Regist	rar's Signatu	% A	porte	1	21.6		1		-	- ( -		
100	Registr	ar		2005	aures 1	~ ~										

			1 - For State Registrar	State of Ma	aryland /		rtmen tificat			and M		gien	2000	39470	
			1. Decedent's Name (First, Middle, Last	7)							2. Date of De			3. Time of Death	_
	Physici /Medic		John N. Remiss	ong							Decemb	er Da	5, 2005	6:20A M	ł
	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location of	of Death		40	. County of Dea	ith	
	19.	380 <u>.</u>	Montgomery Hospic					kvil					Montgom	ery	
п	Funeral		5. Social Security Number 6. Se	X 7.Agu ÖM 2⊟F	e (In yrs. last b 79	Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da	th ay, Year,	9. Bir	thplace (State or Foreign ountry)	7
*	Director		337-12-9068 Usual Residence of Decedent		/9	113.				]	May 27	, 19	26 I11	inois	_
	/land		10a. State 10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits	
	Man Frsh	to	Maryland Montgome	rv	Rockvi	ille								1 ☐ Yes 2√ No	)
	r 28c	rec	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of What C	ountry?	-
	th wit	a D	6001 Muncaster Mi	.11 Road			20	855				Uni	ted Sta	tes	
	dea	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?		13. V			spanic Ori	gin? (Spec	cify Yes or No Rican, etc.)		14. Race - Amo	erican Indian,	_
36	or It	J.	1 Never Married 2 Marned	1 ▼ Yes 2 □ N	™ World		☐ Yes :	22	Specify:	i, i deno i	ticari, etc.)		Black, White Specify:	te, etc.	
Ö	urai',	d by	3₺ Widowed 4 Divorced	Year or Dates:	War II									nite	
5	within 72 hours after death with the Maryland ene. than "natural", or itema 23a or 28e-f ehow ite Madical Examitar must be mullied at	Completed	15. Decedent's Edu (Specify only highest grad		16	(Give i	ent's Usua kind of woi XO NOT us	rk done d	<i>urina</i> mosi	t of workin	g	16b. k	and of Business	/Industry	
12	with:	Ę	Elementary/Secondary (0-12)	College (1-4or 5			Rel	,		onin	lict	Fod	omal Ca	vernment	
0	Hygi Hygi other		17. Father's Name (First, Middle, Last)			abol	. NCI	acio		-	(First, Middle			vernment	_
an	lid be lental ked ked	To Be	Nicholas Remisson	g					Chri	stin	e Haml:	ino			
aryland 21215-0036	shou and N mar	-	19a. Informant's Name/Relationship (T		19	b. Mailin	g Address	(Street a					or Town, State,	Zip Code)	-
Σ	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hyglene. Item 27 is marked other than "natural", or itema 23a or 28e-f show other traumatic event, the Madical Examinar must be notified at		Janice J. Remisso	ng/Daught	er 7	02 6	rand	in A	venue	, Ro	ckville	e. M	aryland	20850	
Baltimore,	of He		20a. Method of Disposition  1 Burial 2 Cremation 3 D	3	20b. Place	of Dispos	sition (Nan	ne of		Decem			ocation - City or		_
Ĕ	Pages ment of I ant: If its ury or o		4 □Donation 5 □ Other (Specify)		Montg Crema	gomer	y um.	Inc.		7, 20	05	Roc	kville.	Maryland	
alt	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral Service Licent	90		22. R.C	Name an	d Addres	s of Facilit	y Robe	ert A.	Pum	phrey F	uneral Home	7
	20229		Maile.	em.	M00803	Ro	ckvi	ile,	Mary	land	20850	)-28	95mery .	uneral Home Avenue	
т			23a. Part1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused ne cause on each lir	the death. Do	not ente	r the mod	e of dying	, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition resulting in death)	End S	tage Pa	rkin	son's	s Dis	sease					Onset and Death	
, ; E-	/Medical Examiner		resulting in death)	Due to (or as	a consequence	of):	-								
В		J.	Sequentially list conditions, if any, leading to immediate	bDue to (or as	2 CODSEGUEDOS	2.05):									_
	nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	200 10 (0) 43	a consequence	oi).									
	al-tra	xai	that initiated events resulting in death) Last	c. Due to (or as	a consequence	e of):		-							
8760	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	call	(	ď											
9	tificat ig phy as th	ledi		J											_
Box	endin	J/N	230. Was decedent pregnant	23c. If yes, outcome 1☐Live birth		h 2	Ectopic pre						23d. Date of de	livery	
H	ed for	sicis	in the past 12 months?  1 Yes 2 No	4☐Pregnant at			Other (sp					ĺ	Month	Day Year	
д. О	res that the death certific igned by the attending p be detached for use as	Physician/Medi	9 Unknown								Ţ				_
ś	igner bed	Ď	Part II. Other significant conditions co Chronic Renal In			in the un	derlying ca	ause give	n in Part 1.		•			the cause of death?	
0	w require been sig should t	Completed	onfonic Renal III	surricient	<i>-</i> y						10	Yes 2	IXINo 3 □ Pi	obably 4 Unknown	
၁ခ	e 2 si	nple									24a. Was	osy	prior to	utopsy findings available completion of cause of	J
Division of Vital Records,	hysician: The law his certificate has b I director, page 2 s										perfo 1 ☐ Yes	rmed?	death?	2□ No	
<u> </u>	sician certif rector	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only o				_
ō	Phys r this ral di	. To	1 ☐ Yes 2 ♣ No	Inpatie	nt 2 ER/C	outpatient Time of			4 🗀 Nui		e 5 Resided Re			city) Hospice	
0	ding I th. : After s funer	tlor	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injui (Month, Da)	Year)	Injury	м	8c. Injury Work 1 □ Y	? es 2 □ N		od. Describe i	now anju	ry occurred		
NSI N	r Attender death rector:	ifica	3 Suicide 6 ☐ Could not be	28e. Place of Inju	ıry - At home, f	arm, stre	et, factory				Bf. Location (	Street ar	nd Number or Ri	ural Route Number.	_
	s afte	Certification:	4  Homicide determined	building, etc	:. (Specify)						City or Tox	wn, State	)	,	
	ospital hours a unerai ( ly fiiled		29a. Certifier  (Check only   Medical Exami	sician: To the best of	of my knowledg	ge, death	occurred a	at the time	e, date and	d place, ar	nd due to the	cause(s	and manner as	s stated.	-
	To the Hospital or Attending Physician: within 45 hours after death To the Funeral Director. After this certifica Completely filled in by the funeral director,	Medical	2332	iner: On the basis of and manner sta	ted.	nd/or inv	estigation,	in my op	inion, deat	h occurred	d at the time,	date an	d place, and due	to the cause(s)	
	To To COT	2	29b. Signature and title of certifier	11				License		10 -		29d. Da	te signed (Mont	, Day, Year)	
	NI		I HUN			M		114	121	18		12	105/	05	
1	5/		30. Name and address of person who or			. , .	,						,		
	Sta	to	Charles Harrise 31 Date filed (Month, Day, Year)		6001 M	unca	ster	Mill	Road	d, Ro	ckvill	e, 1	laryland	1 20855	_
2000	Registr			7 2005		And	Los	age of							

			1 - For Amend Item Registrar	State of Market 1 per phy	aryland 3850 1	/ Depa 2- 7-0 Cer	utment o Las Tificate	f Health of Deat	n and M h	lental Hyç	giene ()	05	39471
	189	,	Decedent's Name (First, Middle, La							2. Date of Dea	ath		3. Time of Death
	Physici /Medic	_	SONNY	<b>──</b>			ROBIN	ISON-		DECEMBE	R 4	Year 2005	5:30 P
	Examin		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Tow		on of Death			unty of Death	
		g+	6711 PARK HEIGH					MORE		,		N	/A
	Funeral			Sex 7. Ag 1 □ M 2 🔀 F	e (In yrs. las	it birthday). Yrs.	If Under 1 You Months Da	ays Hour	ler 24 Hrs. s Min.	8. Date of Birtl (Month, Day	h V. Year)	9. Birth	place (State or Forei
*	Director		Usual Residence of Decedent	Λ	3,5					2/28	120		MICHIGAN
	yland		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limi
	e Ma	cto	MD N	I/A	B	ALTIM	ORE						1√ Yes 2□N
	章 g a g	Director	10e. Street and Number				10f. Zip Coo	de			10g. Citizen	of What Cou	untry?
	death with the Maryland ms 23a or 28a-f ehow must be notified at		6711 PARK HEIGH	· · · · · · · · · · · · · · · · · · ·			212					U.S.A	
0036	hours after death with the Marylar turel; or Items 23e or 28e-f ehow at Examinal must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:		11	Vas Decedent f Yes, specify ( i ☐ Yes 2	Cuban, Mexic	can, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White ecify: WH	ican Indian, ), etc. ITE
ဂ ဂ		Completed	15. Decedent's E (Specify only highest gi			(Give	lent's Usual Ockind of work do	one durina m	ost of work	ing	16b. Kind	of Business/l	ndustry
121	within 72 ene. then "nei he Medic	ig III	Elementary/Secondary (0-12)	College (1-4or	5+)		OO NOT use re			3		TMENT	CTODE
N	filed v Hygie other t		17. Father's Name (First, Middle, Las	t)	1	CUPY	WRITER		thor's Name	e (First, Middle,		TMENT	STURE
and	d be sental	o Be	ALEXANDER	•	V	OLMAN			IEDA	e (1 // St, 14/10016,	walder Sur	,	FEIGIN
چ	shoul nd Ma mari	ဥ	19a. Informant's Name/Relationship	(Type, Print)			g Address (Str			al Route Numbe	r. City or To		
Mar	s 1 and 2 shou f Heelth and M item 27 is mer other treumati		MAUREEN D. ROBINS	SON/DAUGHTE	R					LONGWOOD			,,
ē,	of Hee		20a. Method of Disposition		20b. Plac	ce of Dispos	sition (Name o	f		Date		on - City or 1	Town, State
altimore	nit. Page lartment or ortant: ff injury or		1 XBurial 2 ☐ Cremation 3 ( 4 ☐ Donation 5 ☐ Other (Spec				UNO CON		12/0	6/2005	BALTI	MORE.	MD
ž	permit. Pages Department of important: if it eny injury or o		21. Signature of Funeral Service Lice	insee						LEVINS			
מ	20.E = 9		Toleto !	V.			-					ILLE,	MD 21208
8/60,	The law requires that the death certificate be executed  X X X X X X X X X X X X X X X X X X X	dicai Examiner	23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Arr Due to (or as b. Ye. Due to (or as c. Due to (or as	a consequel	mid ince of): Suff ince of):				tachyc		a	Approximate Interval Between Onset and Death
٥	rdifica ng ph		IF FEMALE:										
C. BOX	of the death certific by the attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3	Ectopic pregna Other (specify		-		23d.	Date of dela Month	very Day Year
ν, J	res the signed I be det	by P	Part II. Other significant conditions	contributing to death b	ut not resulti	ing in the ur	nderlying cause	given in Pa	rt I.	23e. Did to	bacco use	contribute to	the cause of death?
or a	w require been signature	ted	Macillar	algeno	106410	NU				1 🗆 Y	es 2□N	o 3∏Pro	bably 4 Únknow
al Records,		Completed	Spastic dys	phonia						24a. Was a autop perfor 1  Yes	SV	4b. Were aut prior to co death? 1 \(\sum \text{Yes}\)	opsy findings availab ompletion of cause of 2 No
Vital	siciar certif rector	Be	25. Was case referred to medical examiner?	Hospital:				Othor		h (Check anly or			
0	Phys r this rai di	7: To	1 Yes 2 No  27. Manner of Death	28a. Date of Inju		NOutpatien 8b. Time of		40	Nursing Ho	me 5 Resid 28d. Describe h		Other (Spec	ify)
0	ttending P death. stor: After t	謞	1 Accident 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury		injury at Work? 1 ☐ Yes 2			or allary oc		
UIVISION	4 - 9 G	Certification:	3 Suicide 6 Could not 4 Homicide determined	28e. Place of Inj building, et	ury - At hom c. (Specify)	e, farm, stre	eet, factory, off	ice		28f. Location (S City or Tow	itreet and N n, State)	umber or Rui	ral Route Number,
	the Hospital or iin 24 hours efte the Funerel Dir ipletely filled in	edicai	29a. Certifier 1 Certifying P	hysician: To the best miner: On the basis o	f examination	edge, death n and/or inv	occurred at the	ne time, date ny opinion, d	and place, leath occurr	and due to the cred at the time, c	ause(s) and date and pla	manner as	stated. to the cause(s)
)	within 7 To the comple	) Ne	29b. Signature and title of certifier	and manner sta	Man.	~	29c. Lic	bense numbe	364	1	29d. Date si	gned (Month	. Day, Year)
	10		30. Name and oddress of person who	completed cause of o	eath (Item 2	(3a) (Type, 1	Print)	- 01	Dinas	Mils	w	211	17
	Sta	te	31. Date filed (Month, Day, Year)		r's Signatur	re a	1 0		J	/1	111	O(1)	' /
***	Registr	ar	DEC 0	7 2005	The same	B.	gode	<i>K</i>					
DH	MH 17 Pay 1/2	001					*						

V			1 - For State Registrar	State of Marylar		artment of He rtificate of D			ene g. Wo. 05	39472
	Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Edward Daniel Schy     4a. Facility Name (If not institution, give s	wartz street and number)		4b. City, Town, or L	ocation of Death	2. Date of Death Month Dec. 1,	Day Year	3. Time of Death 12:50 P M
	Funeral Director	e <sup>rd</sup>	St. Elizabeth Nurs  5. Social Security Number  216-22-4861  6. Security Number		last birthday) Yrs.	Baltim  If Under 1 Year  Months Days	ore If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	n/a  Year) 9. Birthy Cou	
	ס	or	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimor	10c. Cit	ty, Town or Lo	cation sville		June 28		yland  10d. Inside City Limits  1 □ Yes 2X No
	3a or 28a-	Funeral Director	10e. Street and Number 608 Southmont Road	1		10f. Zip Code	21228	10	g. Citizen of What Cou United S	•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "netural; or iteme 23e or 28e-f show appringuy or other traumatic event, the Madical Examinar must be notified at ance.	by	11. Marital Status 1   ↑   ↑   ↑   ↑   ↑   ↑   ↑   ↑   ↑	12. Was Decedent Ever in U Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates:		Was Decedent of His if Yes, specify Cuban 1 ☐ Yes 🏋 No	panic Origin? (Spi , Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
21215-0036	ad within 72 hogiene. er than "natu	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 12	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occupat kind of work done du DO NOT use retired) ler	ion iring most of work	ng	6b. Kind of Business/In	•
Maryland	nould be file I Mental Hy narked oth	To Be (	17. Father's Name (First, Middle, Last) Edward Morris Schw				Margai		abeth Kelle	
	s 1 and 2 st of Health and item 27 is n other traun		Joan E. Schwartz  20a. Method of Disposition	/Sister	608		Road, Ca	atonsvill	City or Town, State, Zip Le, Marylan Oc. Location - City or To	d 21228
Baltimore,	permit. Pages Department of Important: If I any injury or once.		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature o Funeral Service Licens	Lo	udon Pa	ark Cemete 2. Name and Address	ry   12/5 of Facility Hul	obard Fur	altimore, M neral Home, nore, Maryl	Inc.
8760,	law requires that the death certificate be executed  as been signed by the attending physician and as been signed by the attending physician and as been signed by the attending physician and as been signed by the attending physician and as been signed by the detached for use as the burial-transit	dicai Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect to due to (or as a consect to due to (or as a consect to due to (or as a consect to due to (or as a consect to due to (or as a consect due to (or a))).	clero	. /			20 Msty	Approximate Interval Between Onset and Death July Lewis
P.O. Box 6	that the death certific ed by the attending p detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnant 1 Live birth 2 Feta 4 Pregnant at time of c	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
	w requires that been signed b should be deta	ρ	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause given	in Part I,		acco use contribute to the	
Vital Records,	The ate h page	e Completed	25. Was case referred to medical					-	ed? prior to co death?	opsy findings available impletion of cause of
ō	ding Ph h. After th funeral	ToB	examiner? 1	dospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury	ot 3 DOA Other  1 28c. Injury a Work?	4 A Nursing Ho	me 5 Resider 28d. Describe hov	nce 6 □Other (Specif	y)
Division	o the c	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	fy) 			City or Town,		
•	To the Hospitel or Attenwithin 24 hours after deating to the Funeral Director:	Medical	(Check only 2   Medical Examinations)	sician: To the best of my kno ner: On the basis of examina and manner stated.	ation and/or in	vestigation, in my opii	nion, death occurr	ed at the time, da	te and place, and due to	o the cause(s)
_	1341		30. Name and address of person who are the filed (Month 1997, Year) 7 2	empleted cause of death (Item	n 23a) (Type,	Print) Choi	re les	re fre	et un	121228
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be filed within 72 hores all Hygiene.  1 other than "naturi vent, the Medical Event, The	To Be Completed by Funeral Director	ST. AGNES HOSPITA 5. Social Security Number 6. S	HANDS a street and number)  AL  ex  T. Age  7. Age  12. Was Decedent E Armed Forces? 1   Yes   2   2   Ne   If Yes, Give   Year or Dates:	BALTIM ver in U.S.	yrs.  BA1  If Unc Month  When or Location  MORE  107. 2		on of Death  der 24 Hrs. 8. Da rs Min. (Me	te of Birth Yeer 27 · 193	2005 c. County of Death  N A  9. Birth Cou	place (State or Foreign ntry)  SC  10d. Inside City Limits  1 12 Yes 2 No
/Medical Examiner Funeral Director	To Be Completed by Funeral Director	Aa. Facility Name (If not institution, give ST- AGNES HOSPIT) 5. Social Security Number 6. S 216. 34. 5614  Usual Residence of Decedent 10a. State 10b. County MD NA 10e. Street and Number 2216 RIGAS AVENU 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest grave) Elementary/Secondary (0-12) 12. H. GRADE 17. Father's Name (First, Middle, Last)	estreet and number)  AL  ex  T. Age  7. Age  12. Was Decedent E  Armed Forces? 1	70 10c. City, Tow BALTIM ver in U.S.	yrs.  BA1  If Unc Month  We or Location  107. 2	LTIMORE Her 1 Year If Units Days Hour	der 24 Hrs. 8. Da (Mr. Old	te of Birth Port, Peer 27 193	2 005 c. County of Death N A 9. Birth Cou	place (State or Foreign ntry)  SC  10d. Inside City Limits  1 12 Yes 2 No
Funeral Director	To Be Completed by Funeral Director	ST- AGNES HOSPITA  5. Social Security Number  6. S  Clib. 34. 5614  Usual Residence of Decedent  10a. State  10b. County  MD  NA  10e. Street and Number  CLIC RIGOS AVENU  11. Marital Status  1 Never Married  3 Widowed 4 Divorced  15. Decedent's Ec  (Specify only highest gra  Elementary/Secondary (0-12)  12. H. GRAOE  17. Father's Name (First, Middle, Last)	The second of th	70 10c. City, Tow BALTIM ver in U.S.	yrs.  BA1  If Unc Month  We or Location  107. 2	LTIMORE Her 1 Year If Units Days Hour	der 24 Hrs. 8. Da rs Min. (Mr.	te of Birth Year 27 · 193	N A 9. Birth Cou	place (State or Foreign ntry)  SC  10d. Inside City Limits  1 12 Yes 2 No
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o H T P		20a. Method of Disposition 1		cemete	tery, crematory o	r other place)			V10000V TSV	1.0
it. Pa intmer intenti njury	1	<ul><li>4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Lice)</li></ul>		MT. XI		and Address of Fa	12 - 12 - 05		JIMORE.	MD
permil Depar Impor any ir	0	Vaush C			VAUGHA	C. GREE	ocility NE FUNERAL PIKE BALTI	L SERVICE	E 1229	
		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused	the death. Do						Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	MYOCAR		INFAR	CT				Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a		e of):					
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death certific e attending p id for use as	ian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Ø No	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	2 🗌 Fetal deat	= '	pregnancy (specify)			23d. Date of deli-	Day Year
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w require been sig should b								1 Tes	2 □ No 3 □ Pro	bably 4 Unknow
has be	Completed						24	ta. Was an autopsy	prior to c	opsy findings available ompletion of cause of
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his his	٠. T	1 ☐ Yes 2 X No 27. Manner of Deat	28a. Date of Injur	v 28b	o. Time of	28c. Injury at Work?	Nursing Home 5 28d. D	Residence escribe how inj		ify)
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To the Hospital cambridge of within 24 hours at To the Funeral D completely filled in	edical	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Exe	hysician: To the best of miner: On the basis of and manner sta	examination a	dge, death occurr and/or investigat	ed at the time, dat ion, in my opinion,	e and place, and du death occurred at t	e to the cause( he time, date a	s) and manner as nd place, and due	stated. to the cause(s)
To the Vithin 2 To the Comple	Med	29b. Signature and title of certifier	and manner sta	160.		29c. License numb	per	29d. D	ate signed (Month	, Dey, Year)
F S F O		× 164				D36769	5	DEC	CEMBER	05,2009
3/		30. Name and address of person who	completed cause of de	eath (Item 23a						
/		MELISSA K. E	SUICK M 7 2005	. D	900 C	ATION AY	VE . BAI	JIMOR	E M	D 21229
State Registra		31. Date filed (Month, Day, Year)	32 Registe	r's Signature		4.0			-	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No:-Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** DECOMPER STOKES EVELYN /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner and Govera 7. Age (In yrs. last birthday, NIA 8. Date of Birth (Month, Day, If Under 24 Hrs Birthplace (State or Foreign Country) 6 Sex **Funeral** Davs Months Hours 1□M 2**K**F 212.44.3034 01.09.1943 Director MD Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or itema 23a or 28a-f ehow other traumatic event, its Modical Exeminar must be notified at 1 ¥ Yes 2 □ No BALTIMORE **Funeral Director** MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code STREET 1701 ELMAW 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mentai Hygiene. Important: If item 27 Is marked other then "natural", or Iter 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK CUHNARY 10 14 GRADE NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JERRY STOKES EDITH PAYNE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 N. FULTON AVE. # 3 BALTIMORE MD 212
20c. Location - City or Town, State STOKES SISTER' MAGGIE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date eny injury or o 1 Burial 2 SCremation 3 Removal from State 12.07.05 BALTIMORE 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATI PIKE, BALTO. MO 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to b as a consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregrant 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown 1 ☐ Yes certificate has been si rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an 20 No 1 Yes the Hospital or Attending Physician: : After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Denpatient 2 ER/Outpatient 3 DOA 2 1100 Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number Much Reddy Name and address of person who complete use of death (Item 23a) (Type, Print) Maryland General Hospital 9, MB C

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

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**ORIGINAL** 

General H. Sparke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 8:53 AM SISK JUNIOR DECEMBER 2 2005 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BACTIMORE HAMILTON GENESIS CITY. If Under 1 Year If Under 24 Hrs. Min. Min. Min. Min. (Month, Day, Year) 04/26/1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 12M 20 F 80 223-28-1778 Director Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Department if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat rust be natilited at once. 1 Yes 2 No MD Director Baltimore 10f. Zip Code 10n, Citizen of What Country? 10e. Street and Number 21213 2412 Kentucky Avenue, Frnt. Rm. United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White Specify δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Refuse Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Lark John Sisk Sally Portor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Clifton Weller 2412 Kentucky Avenue Baltimore, MD 21213 / friend Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dec 5 1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory Inc. 2005 Beltsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician METASTATIC CHACINDMA OF UNKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): ORIGIN Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physicien: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of): P.O. Box 68760, Be Completed by Physician/Medical BTRICTUE DU MONTY DI ACE IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐ Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown CONGESTIVE HEART 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No DEPRESSION 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after d 4 Homicide To the Hospital o within 24 hours af To the Funerel D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier DOD 62239 DECEMBER 03, 2005 MAN NOO, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. MANNA NATING ROAD MODIZILA BALTIMORE, 6040 HARFORD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - For Stete Registrar	State of M	Maryland / Dep Ce	ertificate of		Mental Hygien		39477	
	Physici		1. Decedent's Name (First, Middle, Last, Roger T.	Schulze					ay Yeer 6 2005	3. Time of Death 12:10 A M	
	/Medio		4a. Facility Name (If not institution, give	street and number	ar)	4b. City, Town, o	r Location of Death		c. County of Dea		
	Funeral Director		Social Security Number	x 7	Age (In yrs. last birthda)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 7-2-1936	9. Bir	thplace (State or Foreign buntry) ington, DC	
	D		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or i	antian		7 2 1000		10d. Inside City Limits	
	Maryla	tor	Maryland Prince Geor	ge	Laurel	Location				1 ☐ Yes 2 ☐ No	
	or 28a-	Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Co	buntry?	
	s 23a	rai	6715 Parkhall Drive	12 Mas Dasada	at Ever in U.S. 12	20707	line a dio Origina (Sa		ed States		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Items 23a or 28a-f ehow enty injury or other traumatic event, Ira Medical Examinal framelists indifficit at another.	by Funerai	11. Marital Status  1 □ Never Married 2 💢 Married  3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 XI Yes 2[ If Yes, Give Year or Date	™P0/1/61 s: 8/10/62	. Was Decedent of H If Yes, specify Cub. 1 Yes 2 No	Specify:	Rican, etc.)	Black, Whit		
15-0	"natur	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Giv	edent's Usual Occup re kind of work done DO NOT use retire	during most of work	ang 16b.	Kind of Business	/Industry	
21215-0036	iene.	Completed	Elementary/Secondary (0-12) 12	College (1-4d	or 5+)	iness Owner	0)	Med	dical Bill	ing	
Maryland 2	id be filed ental Hyg ked othe c event,	To Be C	17. Father's Name (First, Middle, Last)  Everett Schulze		'			e (First, Middle, Maide Lechliter	en Sumame)		
lary	2 shou and M is mar	_	19a. Informant's Name/Relationship (T)	rpe, Print)				al Route Number, City		Zip Code)	
	1 and Health em 27 ther tr		Lois Schulze (wife)  20a. Method of Disposition		20b. Place of Disp	position (Name of		Maryland 20	J/U/ Location - City or	Town, State	
Baltimore,	Pages tment of tant: If it		1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Fort Linco	ematory or other pla oln Cemetery	11/3	0/2005 Brent	twood, Mar		
Bal	permit Depar Impor eny in	21. Signature of Fuheral Service Licensee  22. Name and Address of Facility Fleck Funeral Home  7601 Sandy Spring Road Laurel, Maryland 20707  23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
		4	23a. Part1. Inter the disease, or compi shock, or heart failure. List only o Immediate Cause (Final				ng, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	a	ral Thrombosis as a consequence of):	<u> </u>				Months	
	Examiner			Lung	Cancer					Months	
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or	as a consequence of):						
90,	icate be executed physician and s the burial-transit	I Exa	resulting in death) Last	Due to (or	as a consequence of):						
68760,	ficate by physic s the b	edical	•	d							
Вох	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as I	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3 t at time of death 5	□Ectopic pregnancy □ Other (specify) _	<i>y</i>		23d. Date of de Mo <i>n</i> th	livery Day Year	
Is, P.O.	res that the disigned by the long detached	by	Part II. Other significant conditions co	ntributing to death	n but not resulting in the	underlying cause giv	ren in Part I.			o the cause of death?	
Records,	w require been signature	leted						24a. Was an		utopsy findings available	
Re		Completed						autopsy performed?	prior to death?	completion of cause of 2 □ No	
Vital	Physician: The this certificate har director, page	Be	25. Was case referred to medical examiner?	Hospital:		- 0#	or	h (Check only one)			
Jo u	og Phys ter this neral dii	n: To	27. Manner of Death	28a. Date of li		of 28c, Injur	4 🗆 Nuising no	28d. Describe how in		cify)	
Division of	Attending or death.	catio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □No				
Divi	tal or Al	Certification:	4 Homicide determined	building,	Injury - At home, farm, s etc. (Specify)	treet, factory, office		28f. Location (Street City or Town, Sta		urai Houte Number,	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai	29a. Certifier 1 ★ Certifying Phy (Check only one)	sician: To the be ner: On the basis and manner	est of my knowledge, deas s of examination and/or stated.	ath occurred at the til	me, date and place, ppinion, death occur	and due to the cause red at the time, date a	(s) and manner as nd place, and due	s stated. to the cause(s)	
	To the To the Comp	M	29b. Signature and title of certifier	A	1Deals	29g Lidens	3916	29d. C	Date signed (Mont	h, Day, Year)	
8	0		30. Name and address of person who co William A. Warren, MD 3				nuland 2070	7	harming C	+1,0ws	
-	Sta	ite_	31. Date filed (Month, Day, Year)	32. R	strar's Signature	Sheeker Ma	ryland 20/0				
	Regist		DEC 0 7	2005	HING IS	7					

		1	For State Registrar	State of M	aryland		rtment o				giene	005	39478
	hysicia /Medic xamin	an al	1. Decedent's Name (First, Middle, Last)  Margaret L. Sul  4a Facility Name (If not institution, give s	livan	hab	Cente	4b. City, Tow	n, or Location	of Death	2. Date of Dea Month	Day	Year 2005 County of Death	3. Time of Death 9:17pm
	ineral ector		192-10-0033			ast birthday)Yrs.	If Under 1 Ye Months Da			8. Date of Birth (Month, Day Apr 20,	, Year)	Cou	place (State or Foreign intry) sylvania
he Maryland	28a-f show	Director	Usual Residence of Decedent           10a. State         10b. County           MD         Harford           10e. Street and Number		10c. City	Bel A		Na.			10g Citiz	zen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
C 21215-0U36 filed within 72 hours after death with the Maryland Hygiene.	ams 23a or er must by r	E .	410 E. MacPhail R	12. Was Decedent Armed Forces'	?	S. 13. W		2.	1014 Origin? (Spe an, Puerto F	cify Yes or No- Rican, etc.)		USA 14. Race - Amer Black, White	ican fndian,
Z1Z15-0036 od within 72 hours afte giene.	natural', or It Ilcal Examin	by	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grade		No	16a. Deced	Yes 2	cupation		na l		Specify: wh:	
d Z1Z1; filed within 7 Hygiene.	d other than "natural", or itams 23s or 28s-f show event, the Medical Exeminer must be notified at	e Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4or	5+)	life. D	nomemal	tired)		(First, Middle,	Maiden	OWN ho	ome
Maryland of 2 should be (ife the and Mental H)	is marked caumatic ev	To Be	Joseph Elza Gathe  19a. Informant's Name/Relationship (Ty Tim Thomas/son				-	reet and Num	ber or Rura		r, City or	r Town, State, Zi	
Baltimore, M permit. Pages 1 and 3 Department of Health	Important: If Item 27 is marke eny injury or other traumatic <u>once</u> .		20a. Method of Disposition  1 Burial 2 Cremation 3 P  4 Donation 5 Other (Specify)	Removal from State	1 0	lace of Disposemetery, crem	sition (Name o	f !		ate		ille, MI cation - City or T	
Baltimo	Importal eny inju once:		21. Six sture   Funeral Service Licens	Nade Div	ector	SB	<u>altimo</u>	natomy re, MD	Board 2120	)1		ltimore	Street
/Me	edical		23a. Part1 Enter the disease, or complet shock, if heart failure. List only or firmediate Cause (Final disease or condition resulting in death)	ne cause / each	line. hrim	evs	4	ment	*	гезрпаюту аг	1651,	,	Interval Between Onset and Death
	whe price of the p	cal Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as									
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed after death.	ed by the attending phy detached for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 □ No 9 □ Unknown	23c. ff yes, outcom 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregn				2	23d. Date of deliver Month	very Day Year
ords, P.	been signed by should be deta	ρ	Part II. Other significant conditions co.	ntributing to death	but not resu	ulting in the ur	nderlying caus	e given in Par	t I.	23e. Did to		1	the cause of death?
al Reco	is certificate has be director, page 2 sh	Completed								1 ☐ Yes	rmed? 2 Z No	prior to c death?	topsy findings available completion of cause of
Division of Vital Records, to Attending Physician: The law requires taller death.	: After this certil funeral directo	tion: To Be	25. Was case referred to medical examiner?  1  Yes  25 No  27. Manner of Death  1,5 Natural  5  Pending 2  Accident investigation	Hospital: 1 ☐ Inpat 28a. Date of In (Month, D	jury	ER/Outpatien 28b. Time of Injury		Othon 1	Nursing Hor	Check only one 5 Residence	dence 6	6 □Other (Spec y occurred	cify)
Divisi	To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inbuilding, 6	njury - At ho	ome, farm, stre	eet, factory, of	fice	1	28f. Location (\$ City or Tox	Street and vn, State,	d Number or Ru )	ral Route Number,
To the Hosp within 24 hou	o the Fune ompletely fil	Medical	29a. Certifier (Check only one)  2 Medical Exami	iner: On the basis	of examina	tion and/or inv	estigation in	my oninion d	eath occurre	ed at the time	date and	I place, and due	to the cause(s)
<b>⊢</b> ≥	Þō		30. Name and address of person who co	ompleted cause of	death (Item	п 23а) (Туре,	Print)	3465	2_	1.	Dece	mber à	2005
	Sta Regist		31. Date filed (Month, Day, Year) DEC 0 7 201	// 2 32 Regis 05	Nürk trar's Signa	h Au	ule!	1511	Air	· Mai	14/	and	2, 2005 2, 2005

SULLIVAN, MARGARET

				partment of Health and Meartificate of Death		giene 199. No. 0 0 5	39479
	Physici	20	Decedent's Name (First, Middle, Last)		2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic		William Clifton Sheppard		ecember)	4, 2005	12:30p M
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th
		- N. A.	103 Sorrento Avenue 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd)	Baltimore    Baltimore   Balti	8 Date of Birth	Q Die	thplace (State or Foreign
	Funeral Director		215-48-6312 1AM 2 F 52 Yrs	Months Days Hours Min.	8. Date of Birth (Month, Day) June 12	Year) 2, 1953 Ma	aryland
	ō		Usual Residence of Decedent		-		
	arylar ehow	ž	10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits 1√2 Yes 2 ☐ No
	8e-1	Director	Maryland Baltimo:				21
	s or	ā	10e. Street and Number	10f. Zip Code	'	log. Citizen of What Co	ountry?
	leath	eral	103 Sorrento Avenue  11. Marital Status  12. Was Decedent Ever in U.S.   1	21229  3. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	USA 14. Race - Ame	ancan Indian
(C)	or Iten	Funeral	1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No	Was Decedent of Hispanic Origin? (Speilf Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, Whit	
21215-0036	within 72 hours after death with the Maryland ene. then 'naturel', or items 23c or 28e-1 ehow the Medical Exeminer mastice notified at	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	White
5-0	72 h	Completed	(Specify only highest grade completed) (G.	cedent's Usual Occupation ve kind of work done during most of workin	ng	16b. Kind of Business.	Industry
2	vithin ne. hen	m p	Elementary/Secondary (0-12) College (1-4or 5+)	. DO NOT use retired)		Fowell Snec	cialities Con
22	Hygie Hygie ther t nt, to		2 Acc	ountant 18. Mother's Name			
an	d be antal	o Be	William W. Sheppard		Shipley	elaloon contant)	
Maryland	Shoull nd Me mark meti	2		iling Address (Street and Number or Rural		r. City or Town, State.	Zip Code)
	nd 2			Sorrento Avenue; B			
ē,	s 1 a of Heis item othe	151	20a. Method of Disposition 20b. Place of Disposition			20c. Location - City or	
Ë	Page nent c int: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  Metro Ci		2005	Catonsville	, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 Is marked other then "naturel", or items 23c or 28e-1 show any injury or other treumetic event, it a Medical Examiner must be notified at once.		21. Signature of Funeral Service vicensee	<sup>22</sup> Name and Address of Facility Witzke Funeral Hom 1630 Edmondson Ave			
n	*		23a. Part1. Enter the diseas, or complications that caused the death. Do not shock, or heart failure, list only one cause on each line.				Approximate Interval Between
6	Physician			arterio scherotic			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)	Disease	Coc. Colo	ou gorpu	
	Lxaiiiiiei	L	Sequentially list conditions, b.	13case			
	pel led	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
	al-tra	xar	that initiated events c				
8760,	The law requires that the death certificate be executed title has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	dicall	d				
9	tificat ng phy as th	led					
ŏ	leath certifica attending ph i for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant  1□Live birth 2□Fetal death	B Ectopic pregnancy		23d. Date of del	
O. B	e dea the at ned fo	Physician/Med		Other (specify)		Month	Day Year
<u>С</u>	that the de led by the a detached f	Ph)	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e Did tol	paged use contribute to	the cause of death?
Records,	w requires that s been signed t should be deta	d by	Hypertension. Hypercholeste	, ,	1 Ye		obably 4 DUnknown
Š	v requestions	Completed	Cigarette Smoker		24a. Was a		
Re	The law ate has page 2	ш			autops	v prior to	itopsy findings available completion of cause of
Vital	(0 1	e Co	Rheumatora arthrifts 25. Was case referred medical	26. Place of Death		2 No 1 Yes	2 No
>	/sicie	0 8	examiner?  1 Yes 2 PNo  Hospital: 1 Inpatient 2 ER/Outpat	0.15		ence 6 Other (Spe	ciful
פֿר	Attending Physicien: or death. ector: After this certification by the funeral director.	n: T	27. Man of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 2		ow injury occurred	any)
ō	ath. rr: After	atio	1 Vatural 5 Pending (Month, Day Year) Injur 2 Accident investigation	M 1 Yes 2 No			
Division of	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office . 2	8f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dirt completely filled in I		29a. Certifier 1  Certifying Physician: To the best of my knowledge, de	ath occurred at the time, date and place, as	nd due to the ca	ause(s) and manner as	stated
	e Horie	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occurre	d at the time, da	ate and place, and due	to the cause(s)
	To the H within 24 To the Fo	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Monti	h, Day, Year)
)	/		Jaurence Galleger, 1	D01786	17	December 5	,0005
	5		30. Name and address of person who completed cause of death (Item 23a) (Type	DO1786  Print) Maiden Choice L	,	1 4	
				Maiden Choice L	are 1	Davo, M	d 2/598
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registi	ar	DEC 0 7 2005				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SCOTT BARBARA 8:32 AM December 2005 /Medical 4a. Facility Name (If not institution, give street and number)

Merry Medical Cli 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8. Date of Birth A. (Month, Day, Year) A. A. H. [9] If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** -8189 Months Hours Min 1 □ M 2 X F Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland to Heaith and Mental Hygiene. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other then "natural", or items 23a or 28a-f ebov 1 Xes 2 □ No Directo Mo 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give/ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify. 0 þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) NIA Disabled 12th NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Bell Jackson 2 James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jest 1 and Hunter (fertrude - SISTER 4546 21215 The Dalto mdi 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removaf from State mem. PK. 112-10-05 4 □Donation 5 □ Other (Specify)

21. Signature of uneral Service Licensee butus 22. Name and Address of Facility
27. OF A HILTON V. march Reneral Home Dalto md, 21229 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 Immediate Cause (Finaf eucephalopathi Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Day Month Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the a page 2 should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 1 Yes 2 No 1 Yes ieral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examinar?

1 7 7 es 2 No Be 26. Place of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation 1 Yes 2 No 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide within 24 hours a To the Funeral C 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical ATENDING 29b. Signature and title of certifier PHYRICIN 3 and address opperson who completed cause of death (Item 23a) (Type, Print) Baltimore ST. Paul MD 201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State DECO Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend/Unpend 1 tem#1, 23a, 27, perME, G850, 12-23-05 TT

				State of Marylan	·			vlental Hy	giene	0.01.01
			State Registrar		Certifica	ate of	Death		Reg. No. UU	39481
	Physicia	an	Decedent's Name (First, Middle, Last)	Kharri Smith	mith			2. Date of De Month	Day Ye	
	/Medic		Kna	The second	45 0	T	or Location of Death	Novemb	er 30, 200	
	Examin	er	4a. Facility Name (If not institution, give st Baltimore Washingto	on Medical Cer	nter Gle	en Bu	rnie		Anne Ar	rundel County
03	Funeral Director		210 11 4017	M 2 X F	Yrs. If Unc Month	er 1 Year S Days	Hours Min.	8. Date of Bir (Month, Da Helo, 2	th ay, Year) 9. 1,2005 V	Birthplace (State or Foreign Country) Maryland
3	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location		,			10d. Inside City Limits
	vith the Marylan or 28a-f show	Director	md AnneARi	endel	Annay	201	lis			1 ☐ Yes 2 No
	h with th	ai Dire	218 COLL	. Arive	101.2	Zip Code 2	-1401		10g. Citizen of What	Country?
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or items 23a or 28a-f show event. If a Mydical Examinat must be notified at	by Funerai	11. Marital Status 1  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	If Yes, s	cedent of h pecify Cub	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		merican Indian, Inite, etc. 2 (a.M.
21215-0036	thin 72 hours e. en "naturel" Medical Ex	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent's U: (Give kind of life. DO NOT	work done	during most of wor	king	16b. Kind of Busine	ess/Industry
	be filed within tal Hygiene. d other than event, it is M		N/A	NIA		$\sim$ /	A Mathada Nas	- Circl Middle	, Maiden Sumame)	77
Maryland		To Be	17. Father's Name (First, Middle, Last)	nith				1 MA		een
Mary	D = D =		19a. Informant's Name/Relationship (Type TIAUNA QUEL	e, Print)	2.5.0		1	mal Route Numb	er, City or Town, State	e, Zip Code) 2 / 40 /
3altimore,	permit. Pages 1 and 2 Department of Health a important: if item 27 if any injury or other tre		20a. Method of Disposition  1 Daβurial 2 □ Cremation 3 □ Re	20b. P	lace of Disposition (A	lame of r other pla	ce)	Date	20c. Location · City	or Town, State
ţ	t. Pages nment of I nant: if it		4 □Donation 5 □ Other (Specify)	A Bes	t Gate me	em. f	ark 12-6	1-05	Annapor	is, md.
Bal	permit. Departrimports any inju		21. Signifure of Funeral Service Libers	ullee	1 an	65 L	v, han	Alin .	Street.	Balto, md,
			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused the death e cause on each line.	n. Do not enter the m	ode of dyi	ng, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Myocarditis  Due to (or as a consequence)	uence of):					
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Understand Cause (Disease or injury	Due to (or as a consequ	uence of):					
	acuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	D						
8760,	tate be executed by sicien and the burial-transit	dicai E	d	Due to (or as a consequ	dence or).					
9	ntificating physes as the	Medi	IF FEMALE:							
P.O. Box	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the ettending physicien and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnation 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of diese. On the control of th	death 3 Ectopic		у		23d. Date of Month	delivery Day Year
S, P	signed by	þ	Part II. Other significant conditions con	tributing to death but not rest	ulting in the underlyin	g cause gr	ven in Part I.	23e. Did 1		e to the cause of death?  Probably 4 Unknown
cord	w requi	leted						24a. Was	^	autopsy findings available to completion of cause of
II Re	The la	Completed						auto perfo 10 Yes	psy ormed? death 2 □ No 1 ☑	1?
Vita	icien: certific ector,	Be	25. Was case referred to medical examiner?	ospital:		Ott	26. Place of Dea			
ð	Phys or this oral dir	7; To	1X Yes 2 No 1" 27. Manner of Death	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3☐ 28b. Time of	28c. Inju	4 LI NUISING I		idence 6 Other (5 how injury occurred	Specify)
sion	ending sath. or: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 19ar)	Injury M		Yes 2 No			
Division of Vital Records,	To the Hospital or Attanding Physicien: The lawithin 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, street, fact y)	ory, office		28f. Location ( City or To	Street and Number of wn, State)	r Rural Route Number,
1	Hospit 24 hour Funera etely fill	Medicai	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death occurr tion and/or investigat	ed at the ti	ime, date and place opinion, death occu	, and due to the irred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	within To the	Me	29b. Signature and title of certifier	On	12	29c. Licen OC.	se number ME		29d. Date signed (M December	
	· In Se		30. Name and address of person who cou	moletad cause of double floor	23a) (Tuna Print)	111	Penn Stre	ot Roll		ryland 21201
1	B. Ba.		Tasha Z Grant	Der M.D.	. 204) (Typo, Fillit)	TTT .	TOTHI DELE	et bal	LINOLE, Fla	
	Sta		31. Date filed (Month, Day, Year)	32. Registrario Signa	iture	reste	,			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) DECEMBER 2005 **Physician** 05:29 Robert Franklin Smith Sr /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical 4b. City, Town, or Location of Death Examiner Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1□M 2□F Yrs. December 7 1929 218 26 4351 Baltimore, Maryland Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show in then "netural", or items 23a or 28a-f ehov the Mudical Examiner must be notified at 1 ☐ Yes 2 ☐ No Funeral Director Towson Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1025 Roxleigh Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 X No Specify: Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12 WΑ Finance Manager Martin Marietta Ith and Mental Hygis 27 is marked other intraumatic event, in 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Henry Franklin Smith Anna Marie Scheeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: if Item 27 is eny Injury or other traugones. Alma Smith (Wife) 1025 Roxleigh Road Towson, Md. 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc Dec. 6 2005 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility Lassahn FUneral Home Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASYSTOLIE **Physician** /Medical Due to (or as a consequence of) Examiner PULMONARY EMBOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9∏ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 □Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 1 Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Certification: To Be Other: Hospital: 1 Yes 20 No ≥ ER/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Direct 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

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TOWSON, MARYLAND 21204

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31. Date filed (Month, Day, Year)

ROBERT

STOLTZ,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2005

M.D.

32. Fegistrar's Signatur

Carrie and

Division of Vital Records, P.O. Box 68760,

Maryland 21215-0036

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death December 5, 2005 Year **Physician** Joseph F. Shaller 9:40 A. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Multi Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, July 10, 1 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Sex XXM 2□F **Funeral** Hours 85 216-01-7082 Maryland Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examiner must be nutilized at 1 ☐ Yes 2 No Lutherville Baltimore Director Mary land 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 12251 Round Wood Road USA or Items 23a Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 TYes 2 No WWII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Life Insurance Agent Prudential permit. Pages 1 and 2 should be file Depirtment of Health and Mental Hy, Importent: if item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Shaller Katherine Bauer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 304 Kendall Road Baltimore, MD 21210 Deborah M. Shaller/Daughter 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Mem. Gardens 12/9/05 Timonium Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 stena 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician HOUR S /Medical Due to (or a a consequence of): Examiner neumoma Sequentially list conditions, it say, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or a con equence of) Box 68760. Be Completed by Physician/Medical the IF FEMALE for use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 🗌 Yes 2 No 1 Yes in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 ☑ No 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After 1 Natural 5 Pending investigation 1 Tes 2 No after death. 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel L 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier B072717 elesto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DELGABO FERNANA

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

			1 _ For	State of Ma	•				nd Menta	l Hygie	ene		
			Registrar			Certifica	te of	Death			NO.	E	39484
	Physici	an	Decedent's Name (First, Middle, La	st)			0	1	Mor		Day	Year	3. Time of Death
	/Medic	cal	ZOHN	В.			2	HANI		2		05	09:35AM
	Examir	er	4a. Facility Name (If not institution, giv		1. 4	4b. City		Location of I			4c. County o	f Death	N/A
			5. Social Security Number 6. S		(In yrs. last birt	bday) If Unde	or 1 Year	M OR	- Company	of Birth		O Diah	
Ь	Funeral Director		,	MM 2□F		rs. Months			Min. (Moi	ith, Day, Y			place (State or Foreign
	ס		Usual Residence of Decedent					1	Aug.	12,1	.930		Maryland
	rylan	_	10a. State 10b. County		10c. City, Town	or Location						1	0d. Inside City Limits
	Ba-f.s	cto		timore				Dund	alk				1 ☐ Yes 2 🔂 No
	vith th	Director	10e. Street and Number	Marx		10f. Z	p Code	21222		10g	. Citizen of Wh	nat Cour	ntry?
	s 23s		4217 Riversedge	-							United		
	ltem Item	nue	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li></ul>	12. Was Decedent E Armed Forces?		13. Was Dece	edent of H ecify Cuba	ispanic Origin In, Mexican, F	n? (Specify Yes Puerto Rican, e	s or No-		<ul> <li>Americ</li> <li>White,</li> </ul>	ean Indian, etc.
36	hours after death with the Maryland tural; or Items 23a or 28a-f show at Examinant trust be notified at	by Funeral	3 Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1		1 ☐ Yes	2 🙀 No	Specify:			Specify:		White
21215-0036	2 hou	ted	15. Decedent's Ed	lucation	16a.	Decedent's Usu	al Occup	ation		16	b. Kind of Busi	iness/Inc	dustry
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	filed with Hygiene other tha	Con		4 Years		Supervi	sor			R	ecreat	ion	& Parks
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<u>X</u>	should be ind Mental is marked or	2	John H. Shank						garet I				
Maryland	2 shd and ls m	1	19a. Informant's Name/Relationship (	**					or Rural Route				
	s 1 and 2 should be fitted within 72 hours after death with the Marylan if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, it a Medical Examinatinal Landelling at		Mrs. Patricia A.  20a. Method of Disposition	Snank (WI	1000	421 / K1 Disposition (Na		eage wa	ay Dun				21222
altimore,	Pages nent of H nnt: If Ite ury or of		1X Burial 2 ☐ Cremation 3 ☐		cemetery	, crematory or	other plac				c. Location - C	•	
	permit. Pag Department Important: eny injury c		*4 □ Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer		Sacre		-		m. 12/9	/2005	Dund	alk,	Maryland
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	Dharatatan		shock, or heart failure. List only Immediate Cause (Final	one cause on each line	).			9,		arroot,			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		consequence of		MO					_	
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		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence o	f):		10(00	TITUS				W DHIS
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×		/Me	IF FEMALE:	23c. If yes, outcome of									
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o.	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	me or deam	5 Other (s	оөспу)						,
<u> </u>	igned by	y Ph	Part II. Other significant conditions o	ontributing to death but	not resulting in	the underlying	cause give	n in Part I.	23e	. Did tobac	co use contrib	ute to th	e cause of death?
Records,	law requires that the as been signed by th 2 should be detache	d by	I DIOPATHIC	Throma	DOTTOP	ENLA				1 🗆 Yes	2 No 3	☐ Proba	abiy 4 🗆 Unknown
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ž	<u>ө</u> - е	Completed							-	autopsy	? dea	ith?	osy findings available inpletion of cause of
Vita	ician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of	Death (Check		No   IL	Yes	2 No
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n 01	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day)		me of :	28c. Injury Work				njury occurred		,
20	Attendideath. ctor: A y the fu	catio	2 ☐ Accident investigation			М		res 2□No					
DIVISION	or Atten after deat Director: in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, farr <i>(Specity)</i>	n, street, factor	y, office		28f. Loca City	tion (Street or Town, St	and Number ate)	or Rural	Route Number,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1.★ Certifying Ph (Check only 2 Medical Exam	ysician: To the best of liner: On the basis of e and manner state	ixamination and	death occurred or investigation	at the tim i, in my op	e, date and pl inion, death o	place, and due to occurred at the	o the cause time, date	e(s) and mann and place, and	er as sta due to	ated. the cause(s)
	o the	Me	29b. Signature and title of certifier	1		29	c. License	number		29d.	Date signed (/	Month, D	Day, Year)
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	HIN		30. Name and address of person who	completed cause of dea	ith (Item 23a) (T	ype, Print) "	(C2.	- 00 S HOD	OU LAIC TE	DUL	15/11/20	CCC	7
1	// /		ANTOINETTE M. VAL	ENTIMO	4940	EASTE	RNE	T 3VX	BACTIO	10RS	mp	21	224
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	has	the state of						
	Registr		DEC 0	completed cause of dea ENTIMO 32! Registrar 7 2005	we D.	19	)						
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician December 02, 7:00 a 2005 **VELMA** R. SHUEY /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of Glen Burnie Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 8. Date of Birth (Month, Day, Year) August 23,1921 Pennsylvania 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 200 F 218-32-9915 84 Yrs Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State s 23a or 28a-1 show 1 ☐ Yes 2 No Maryland Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 1885 Gordans Court U.S.A. Funeral Items ? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 1 No White δ 3 ☑ Widowed 4 □ Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any lightly or other traumatic event 2008. Pau1 Folkenroth Alberta Ε. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Diffenderfer (Son) 21655 7660 Tall Tree Lane, Preston, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park 12-06-2005 Glen Burnie, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S vice Licensee McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1 dar /Medical Due to (or as a contequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o) as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical the use as signed by the attending I be detached for use as 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 12 No 1 Yes 1 Yes 20 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Mursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes /2 ☑No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral of 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide within 24 hours a To the Funeral I 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 630 meul Name and address of person who completed cause of death (Item 23a) (Type, Print) 202 WMAPLERD, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:00Av 2005 Harry Vultanski NOV /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE
If Under 1 Year | If Under 24 Hrs. ST. AGNES HOSPITAL 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1 M 2□ F Hours Yrs. Director 185-14-1740 83 5, 1922 Pennsylvania Apr Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or itame 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☑ No Catonsville Baltimore Funeral Direc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Maiden Choice Lane #43 21228 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🏋 No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) barber unk cosmotology ages 1 and 2 should be filed onto of Health and Mental Hygie 1: if item 27 is marked other if or other traumatic event, if other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unk unk 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk Michelle Anolik/niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
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eny injury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Chesapeake Crematory 12/14/05 Reltsville MD state 21. Signature of Funeral Service Licensee te Anatomy 21201 8717 Green Pastures Dr. Baltimore

Approximate 21220
Interval Between
Onset and Death Baltimore, MD Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart faifure. Immediate Cause (Final disease or condition resulting in death) ARRYTHMIA **Physician** E ARDIAC 20 MIN /Medical Due to (or as a consequence of) Examiner PANCREATITI 30 HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ysicien and e burial-transit law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical use as the IF FEMALE 23c. ff yes, outcome of pregnancy
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4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 Unknown 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 2 No 3 Probably 4 □Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
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2 Medican Examiner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 19384 2005 leted cause of death (Item 23a) (Type Print) 30. Name and address of person

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31. Date fifed (Month, Day, Year)

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2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month /Z Year 16.35 M **Physician** Weisenmille 01 2005 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Good SAMAritan Bultimore HOSPita If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day Yea Birthplace (State or Foreign Country) **Funeral** 216-56-67-38 55 Days Hours 1 ☐ M 2 🔭 F Director with the Maryland 10c. City 10a. State 10b. County Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? Items 23e 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Deceden 14. Bace - American Indian. 11. Marital Status Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1□ Yes 2XNo Specify: 3 ☐ Widowed 4 ☐ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life: "QO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry oe filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Unk 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) UNK 12 should be fill and Mental H 7 Is marked oth Be permit. Pages 1 and 2 should be Department of Health and Mental Importent: If Item 27 1s marked eny injury or other traumatic ev 9068. 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, Stree, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1. Kandallstown, MD 21133 veisen miller 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ★Cremation 3 ☐ Removal from State ° 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licentee 23a. Part1. Enter N disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD 21229 Approximate Interval Between Onset and Death mmediate Cause (Final myocardial Physician Acute HOLETS disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner cause, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, oul inouary 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Fune		5. Social Security Number 6. S	ex Age (II	n yrs. last birthd	Month		nder 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. 8	inthplace (State or Foreign Country)
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5-0036 72 hours after death with the Maryland	To Be Completed by Funeral Director	3 Bayou Court			1	21220			USA	,
fer dea	FLIDA	11. Marital Status 1 □ Never Married 2 ☑ Married	12. Was Decedent Eve Armed Forces? 1 ™Yes 2 □ No		13. Was Dec If Yes, sp	edent of Hispanic ecify Cuban, Mex	Origin? (Spec cican, Puerto P	cify Yes or No- tican, etc.)	14. Race - An Black, Wh	ite, etc.
9036 ours aff	l yd b	3 ☐ Widowed 4 ☐ Divorced	1 ☑Yes 2 □ No If Yes, Give KO Year or Dates: COI	rean oflict	1 🗆 Yes	2⊠ No Spe	cify:		Specify: W	hite
	Diete	15. Decedent's Ed (Specify only highest gra	ducation de completed)	16a. De	ecedent's Us live kind of v	ual Occupation ork done during i use retired)	most of workin	g	6b. Kind of Busines	•
d 2121 filed within Hygiene.		Elementary/Secondary (0-12)	College (1-4or 5+)		_	reman		Si	melting P	lant
C Sigh	80	17. Father's Name (First, Middle, Last) Henry Rudolph We						(First, Middle, M Grinath	•	
and and and and and and and and and and		19a, Informant's Name/Relationship (				ss (Street and Nu	imber or Rural	Route Number,	City or Town, State,	Zip Code)
e, M Health Health		Hazel M. Weber ((V		Total Control of the		ourt Bal			220 Oc. Location - City o	r Town State
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Baltimore, permit. Pages 1.9 Department of Her Importment of Her Importment of Her	once.	21 Signature of Juneral Service Licer		-	22. Name	and Address of Fa Zinski F	acility			,
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Physici	ian	shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	_		,		,		Interval Between Onset and Death
/Medic Examir		resulting in death)	Due to (or as a co	onsequence of):						
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Box 68760, leath certificate be exampled attending physicien for use as the burie	Medi	IF FEMALE:	00. 11						- p-======	
Box 66 death certific	ician	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p  1 Live birth 2   4 Pregnant at time	Fetal death	3 Ectopic				23d. Date of de Month	Blivery Day Year
P.O. that the deed by the	by Physician/Med	9 Unknown	9□ Unknown					V		
0 8 E E	A P	Part II. Other significant conditions of	ontributing to death but no	ot resuiting in th	e underlying	cause given in Pa	art I.	23e. Did toba	1	robably 4 Unknown
ecord law requires been s	ų Ω							24a. Was an autopsy	24b. Were a	utopsy findings available
al Re	Con							performe	g/? death?	completion of cause of s 2 No
f Vital ysician: '	To Be	25. Was case referred to medical examiner?  1 \( \sum \text{Yes} \) 2 \( \text{No} \) No	Hospital: 1 Inpatient	2 EP/Outpa	tient 3□□	104		Check only on	ce 6 ☐Other (Sp.	20(4)
on of Vita ding Physician: After this certific	L : UO	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Ye	28b. Time	e of	28c. Injury at Work?	28	3d. Describe how		Scriyy
/islo Attendii r death.	8 6	2 Accident Investigation 3 Suicide 6 Could not be determined		- At home, farm,	M street, facto	1 ☐ Yes 2		Bf. Location (Stre	et and Number or F	Tural Route Number
DIVISION IN STATE OF AUTOMATICS AT INC. THE COLUMN IN STATE OF THE C	Certi	4   Florificide						City or Town,	State)	
To the Hospitel within 24 hours at Conferent Lt.	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicaf Exan	ysician: To the best of mainer: On the basis of examiner and manner stated.	amination and/oi	eath occurre r investigatio	d at the time, date n, in my opinion,	and place, and death occurred	nd due to the cau d at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
To the within 2 To the complete	Me Me	29b. Signature and title of certifier			29	c. License numb	er	290	d. Date signed (Mon	th, Day, Year)
-		1/4/				0005503	•	1	2/4/200	S
571	6	30. Name and address of person who	ompleted cause of death	. 50	De, Print)	Squar	e DR	Baltin	nore N	10 21237
Reg	State jistrar	31. Date filed (Month, Day, Year)	32. Redistrar's 2005	Signature	Sperk				<u> </u>	

			For State Registrar	State of I	Marylan	-	artment of rtificate o			lental Hy	giene 2	05	39491
10	Physici	ِ an	Decedent's Name (First, Middle, La FRANK THOMA)		JR					2. Date of De Month	eath Day	Year	3. Time of Death
1	/Medic		4a. Facility Name (If not institution, giv				4b. City, Towr	n, or Locati	ion of Death	NOVEM	BER 26,		9:54A M
100			FREDERICK MEMORIA			to a state to 1	FREDER		der 24 Hrs.			ERIC	
	Funeral Director		5. Social Security Number 214-28-1004	M 2□F	74	last birthday) Yrs.	Months Day			May 1	, Year 931	9. Birthp Mary	lace (State or Foreign Tand
	land W		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ly, Town or Lo	cation					1	0d. Inside City Limits
	a-f sho	ctor	Maryland Frederi	.ck	Fre	ederick							1 □ Yes XXNo
	h with the	ai Director	10e. Street and Number 8830 Reichs For	d Road			10f. Zip Code 2170				10g. Citizen of U.S.A.	What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If Item 27 is marked other then "natural'; or Items 23e or 28e-f show ship injury or other traumatic event, the Medical Eventinal matal its notified at ADDE.	by Funerai	11. Marital Status  1 Never Married 2XXMarried 3 Widowed 4 Divorced	12. Was Decede Armed Force XX Yes 2 If Yes, Give Year or Date	es? □ No	1	Was Decedent of Yes, specify C	uban, Mex	ican, Puerto	ecify Yes or No Rican, etc.)		ce - Americ ick, White, by: Whi	etc.
21215-0036	"natur	Completed	15. Decedent's E (Specify only highest gra			(Give	dent's Usual Occ kind of work do	ne during r	nost of worki	ing	16b. Kind of B		
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Maryland	hould d Men marke	၉	Frank Thomas  19a. Informant's Name/Relationship (	/	r.	19h Mailio	ng Address (Stre			ine Lir	Inger er, City or Town,	State 7in	Codel
	and 2 saith ar a 27 is	, di	Mrs. Barbara A. Z	•	е						ck, MD		
Baltimore,	Pages 1: ment of He ent: If Iten ury or oth		20a. Method of Disposition  2 Surial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specif		20b. F	Place of Dispo semetery, cren Int Oliv	sition (Name of natory or other p et Cerrete	olace) <b>Ty</b>		29 <b>,</b> 20	20c. Location 05 Fre		
Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licer	J. C.J	MOO25	55 <b>1</b> 0	Keeney 6 East	and Churc	Basfor ch St.	rd PA F , Frede	uneral rick, M	Home D 217	01
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ds,	uires ti signe	þ	Part II. Other significant conditions of	7 -	crete	•	nderlying cause	giv <i>e</i> n in Pa	art I.	1	obacco us <i>e</i> cont Y <i>e</i> s 2 □ No		e cause of death? ably 4 □Unknown
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/ital		Be C	25. Was case referred to medical examiner?						lace of Death	1 ☐ Yes (Check only o		1 🗆 Yes	20 No
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Divis	200	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Place of	Injury - At ho	ome, farm, stre	eet, factory, office	:e	2	28f. Location (S City or Tox	Street and Numb vn, State)	per or Rura	Route Number,
	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edicai	29a. Certifier 1 Check only one) 1 Medical Exam	ysician: To the be niner: On the basis and manner	or examina	wledge, death tion and/or inv	occurred at the	time, date y opinion, o	and place, a	and due to the ed at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
1	vith Com	2	28b. Signature and title of certifier				29c. Lice	nse numb	er		29d. Date signe		
Í	(Ye)		30. Name and address of person who	completed cause of	f death (Item	1 23a) (Type, I	Print)	) 2	2101		Murm	420	2001
	, U		Lland HAL	or Sun (	W	1475	fan	a	ul,	Frede	vick 1	vol:	7 (76)
43	Sta Registr		31. Date filed (Month, Day, Year)  DEC 0 7 200		strar's Signa	Soare Soare	W)		C			,	

			For Stete	State o	f Marylan		artment of F			giene Reg. No. 2	105	20100
			Registrer  1. Decedent's Name (First, Middle,	Last)			inouto or		2. Date of De.	ath		3. Time of Death
	Physici /Medio		Jesse S.	Ayton	, Jr.				November 1	er 17	Year 2005	13:27 M
	Examin		4a. Facility Name (If not institution,					r Location of Death	1	4c. County		
			Montgomery Gen  5. Social Security Number	Sex,	7. Age (In yrs.	last hirthday)	Olney If Under 1 Year	If Under 24 Hrs.	8. Date of Birl		ntgom	place (State or Foreign
	Funeral Director		217-36-8676	1 <b>X</b> M 2□F	64	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 9 1941	Cou	ntry)
	pu .		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryla f sho	ō		gomery	100.01		ersburg					1 Tyes 2 No
	r 28e-	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cou	ntry?
	th with	ai D	6020 Olney-Lay	tonsvill	e Road			20882		Unit	ted S	tates
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23e or 28e-f show aumatic event, the Medical Fraction and be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Marrie  3 □ Widowed 4 ⊠Divorced	Armed Fo	2 ⊠ No ve		Was Decedent of H fYes, specify Cuba 1 ☐ Yes 2 █KNo	lispanic Origin? (S) an, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	- 14. Rad Bla Specif	ck, White,	can Indian, , etc. White
5-0036	2 hou latura	ted	15. Decedent's	Education			tent's Usual Occup		kina	16b. Kind of B	usiness/Ir	ndustry
2	ithin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (		life. I	kind of work done DO NOT use retired	<i>i</i> )	All ig			
2	illed w Hygiei ther ti	e Col	12 17. Father's Name (First, Middle, La	o (ast)		Equ:	ipment Op	erator  18. Mother's Nam	ne (First, Middle,			Department
au	lid be lental ked o	o Be	Jesse S. Ayt	•				Ethele		Walter		
2	permit. Pages 1 and 2 should by Department of Heelih and Menta Important: if item 27 is marked any injury or other traumatic angones.		19a. Informant's Name/Relationshi John W. Ayton			1	ng Address (Street Olney-La					g, Md.20882
altimore,	of Hee		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3			Place of Dispo	sition (Name of natory or other place	ca)	Date	20c. Location	City or T	own, State
Ĕ	ment of the lant: If its jury or o		'4 □ Donation 5 □ Other (Spe			etropo:	litan Cre	m. 11	/20/05	Alexa	ndri	a, Va.
Ball	permit. Departr Imports any injt		21. Signature of Funeral Service Li	Sensee B	arhe			ss of Facility Barber Ox 5038,			bM	20882
			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that only one cause on e	caused the deat each line.	h. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
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gox	The law requires that the death certific tte has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 Live t	tcome of pregna pirth 2 Peta	I death 3	Ectopic pregnancy				ite of deliv	ery Day Year
O	that the dended by the and detached f	ysic	1 □ Yes 2 □ No 9 □ Unknown	4⊟Pregr 9⊟Unkn	nant at time of d own	eath 5	Other (specify) _					
<del>ر</del> .	res that igned by	by Ph	Part II. Other significant condition	s contributing to d	eath but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to t	the cause of death?
rds	w require been sig should b	ed b							101	res 2 XNo	3 🗌 Proi	bably 4 Unknown
ecc	law re las be	Completed							24a. Was autop	sy	prior to co	opsy findings available ompletion of cause of
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<u>=</u>	siciar certif	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatien	it 3□ DOA Oth	er. 4 Nursing H	th (Check only of ome 5 Resid		nas (Canai	4.1
o	Attending Physician: r death. sctor: After this certification the funeral director.	<b> -</b>	27. Manner of Death	28a. Date		28b. Time of Injury			28d. Describe I			iy)
Sio	endin sath. or: Afi he fur	atlo	1 Natural 5 Pending 2 Accident investiga	tion	, Day 7 dai			Yes 2 □No				
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_	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical Ce	(Check only 2 Medical E:	<b>ceminer:</b> On the b	asis of examina	wledge, death	n occurred at the tir	ne, date and place pinion, death occu	, and due to the	cause(s) and made and place,	anner as s	stated.
	To the I within 2. To the I complete	Med	one)  29b. Signature and title of certifier	and man	ner stated.	$\circ$	29c. Licens			29d. Date signe		
5	% ≥ F 8		Alone de	1 Section	1, MD			16458				18, 2005
	Mr.		30. Name and address of person w									
			Thomas E. Doole 31. Date filed (Month, Day, Year)				gia Aven	ue, Olney	, Maryl	and 2	0830	
	Sta Regist			2005	Registrar's Signa	E POPE	Marie De la Company de la Comp					

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			For Stete	State of Maryl				id Mental Hy	gieņe	nns	201.02
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	Physicia	an	TRIAL A	RNAIC	FR			Month	Da	_	3. Time of Death
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	Examin	er	Shady Grove Adve		· = 1		ckville	Jean			
4.	Funeral		5. Social Security Number 6. Se		yrs. last birthday	/) If Under 1	rear If Under 24		th	Montgome 9. Birth	pplace (State or Foreign untry)
	Director		579-10-9106	⊒M 2X□F 8	36 Yrs.	Months D	Days Hours	Min. (Month, Da			ington, DC
	D .		Usuat Residence of Decedent  10a. State 10b. County	100	City Town and						
	sho	'n	10a. State 10b. County	100	. City, Town or I	Location					10d. Inside City Limits 1 ☐ Yes 2√☐ No
	the N	Directo	Maryland Montgom  10e. Street and Number	ery	Bethes	da 10f. Zip Ci	ndo		10g Cit	izen of What Cor	
	Mith Ba or	Dir	5203 Danbury Road			2081					untry :
	death with the Maryland ma 23a or 28a-f show r must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13			n? (Specify Yes or No Puerto Rican, etc.)		SA 14. Race - Amer	ncan Indian,
	or He		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X				Puerto Rican, etc.)	ļ	Black, White	
9500-612	d within 72 hours atter death with the Marylan speed. The marylan than "natural", or itema 23a or 28a-f show the Medical Examination at the modified at	d by	3 A Widowed 4 ☐ Divorced	Year or Dates:		ILI Yes 20	No Specify:			Specify: Whi	.ce
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Z	within 72 ene. than "na te Medic	mp	Elementary/Secondary (0-12)	College (1-4or 5+)		ookkeer			7		
N	be filed vital Hygie of other f		17. Father's Name (First, Middle, Last)			ookkeet		Name (First, Middle,		counting (Sumame)	
/iand		To Be	George F. Hirsch	man			Mabe:	l Columbus	5		
ar Z	shou ind M mar umat	_	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mai	ling Address (S	Street and Number of	or Rural Route Numbe	er, City o	or Town, State, Z	ip Code)
Mar	alth a alth a 27 h		Eva Hansson/ Fri	end	930	7 Holla	nd Avenue	e, Bethesd	la, I	Maryland	20814
<u>5</u>	irmit. Pages 1 and 2 should be apartment of Health and Menta aportent: if Itam 27 is marked yo injury or other traumatic every injury or other traumatic ever every.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		Ob. Place of Disp cemetery, cr	osition (Name ematory or othe		Date Ovember 17	20c. L	ocation - City or 1	Town, State
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Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licen.	600	F	rancis	Address of Facility	ns Funeral	Ног	ne Inc	
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that daused the e	death. Do not e	nter the mode of	of dying, such as ca	rdiac or respiratory ai	rrest,		Approximate Interval Between Onset and Death
<b>&gt;</b> I	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		Mon	a				
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Ĭ	The lav	Eo							osy ormed? 2. No	death?	ompletion of cause of
Vital	ysician: Th ns certificate director, pag	Bec	25. Was case referred to medical examiner?				26. Place of	Death (Check only of		12.03	
01 <	Physic this ce al dire	To	1 Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpati	ent 3 DOA	Other: 4 Nursi	ng Home 5 Resid	dence	6 ☐Other (Spec	ufy)
ב ס	ding Ph I. After th funeral		27. Manner of Death 1.☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	28b. Time Injury		. Injury at Work?	28d. Describe I	how inju	ry occurred	
<u> </u>	Attendi death ctor: A y the fu	cati	2 Accident investigation 3 Suicide 6 Could not be			М	1 ☐ Yes 2 ☐ No				
Division	il or Attend after death Director: /	Certification:	4 Homicide determined	28e. Place of Injury - building, etc. (S)	oecify)	street, factory, o	iffice	28f. Location (S City or Tox	Street ar wn, State	nd Number or Rui e)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Ph	ysicien: To the best of my	knowledge des	ath occurred at	the time, date and r	place, and due to the	causo/-	and manner as	stated
	e Hoo	edicai	(Check only 2 Medical Examone)	iner: On the basis of example and manner stated.	mination and/or	investigation, in	my opinion, death	occurred at the time,	date and	d place, and due	to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier	114 1 12			icense number			te signed (Month	
	y		by the M	L MIS	•	(	53263	5	11/	18/20	05
	•		30. Name and address of person who	and a	(Item 23a) (Type	e, Print)	a	0 -			
No. of			HAKIM MORSL	-1, MD 99	101 ME	DICAL	LENTER	DK, ROC	KV	ILLE, N	10 20850
	Sta Registi		31. Date filed (Month, Day, Year) NOV 2 1 2(	32/Registrar's S	algitature .	arte					

ndrew	A.	Aderibigh	oe
		, F	٥r

1 = State Registrar

State of Maryland / Department of Health and Mental Hygiene

			-407
te of Death	Reg. No	0 (	5

	Physicia /Medic Examin
Ī	Funeral Director
Baltimore, Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or iteme 23s or 28s-f ehow eny injury or other traumatic event, the Medical Examination must be notified at once.
*	Physician /Medical Examiner

Certificat 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month November 16,2005 10:30 P <sup>™</sup> <u>ADERIBIGBE</u> al 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Hyattsville

Winder 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) 3408 55th Ave. Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2□ F 23 577-19-4270 MARCH 17,1982 MARYLAND Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MDPRINCE GEORGE HYATTSVILLE 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3408 55th AVE 20784 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No II Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th TELEMARKETER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ELIJAH ADERIBIGBE PATRICIA FREDERICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELIJAH A. ADERIBIGBE/FATHER 3408 55th AVE HYATTSVILLE, MD 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MT. OLIVET CEMETERY 11/28/2005 WASHINGTON, DC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lafture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Pinal Contact gunshot cound disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2∑ No 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$ Other (Specify) Scene Hospital: 은 1 XYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury Certification; 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 1 Natural 5 Pending Formel 22:00 investigation 1 ☐ Yes 2 No us ject Found 11/16/05 2 Accident 3 Suicide 4 ☐ Homicide 6 Could not be 28l. Location (Street and Number or Rural City or Town, State) 3408 551 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) ume Yattsville, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. After thi funeral 

31. Date filed (Month, Day, Year)

LAB 14CC/AH

29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

NOV 2 3 2005

Medical

State Registrar 111 Penn Street, Baltimore, Maryland 21201

29c. License number

**OCME** 

29d. Date signed (Month, Day, Year)

November 17, 2005

			For State Registrar	State	of Maryla	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H te of L	ealth and Death	Mental H	ygiene Reg. No.	~ ~ ~ ~	39495
	**	rš.	1. Decedent's Name (First, Middle,	Last)	-			_		2. Date of D	eath Day	Yea	3. Time of Death
Н	Physicia /Medic		Emma	Jewe1	1	At.	kinso	n		NOVEM			005 21:08 <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	give street and n	umber)				Location of Deat	h	4c.	County of De	
		1	MEMORIAL HOSPITA	T.			CUM	BERLA	AND		A	LLEGAN	Y
**	Funeral			. Sex	7. Age (In yrs	s. last birthday)		er 1 Year	If Under 24 Hrs Hours Min.				irthplace (State or Foreign Country)
	Director		218-16-2901	1 ☐ M 2 🂢 F	81	Yrs.	Mortu	Days	Tiours will.	09/26/			est Virginia
	D .		Usual Residence of Decedent		10.0								Tarte de la constitución
	how	_	10a. State 10b. County		100.0	City, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🏹 No
	Ba-f	cto	MD Alleg	any		Cu	mberl				,		
	ith tr	Director	10e. Street and Number				10f. 2	ip Code			10g. Citi	zen of What	Country?
	23a		10107 Hillo						502			USA	
	en de	Funeral	11. Marital Status	Armed I		U.S. 13.	Was Dec If Yes, sp	edent of Hi ecify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or Note Rican, etc.)	10-	14. Race - Ar Black, Wi	nerican Indian, nite, etc.
36	or l		1 Never Married 2 Marrie	If Yes. C	2 XNo Sive		1 🗌 Yes	2X No	Specify:			Specify:	White
21215-0036	urel'	d by	3	Year or	Dates:	L son Dove	44-1I-	-10			10h K		
7	"nat	Completed	15. Decedent's (Specify only highest	grade completed	1)	16a. Dece	kind of v	vork done d use retired	luring most of wo	rking	100. K	nd of Busines	symdustry
2	within	m d	Elementary/Secondary (0-12)	College	(1-4or 5+)				,		**		
	filed within 72 hours after death with the Maryland Hygione. ther than "naturel", or Iteme 23a or 28a-f ehow ent, Itte Medical Exatta net must be motified at	ပိ	17. Father's Name (First, Middle, La	ist)		Home	maker		18. Mother's Na	me (First, Midd	e, Maiden		
Maryland	9 4 5 5	Be C	John	Wilson		George			Flossi	0	Bon	trice	Smith
2	ss 1 and 2 should to the the thank Ment litem 27 ie marked rother traumatic e	5	19a. Informant's Name/Relationshi				na Addre	ss (Street a	and Number or R				
<u> </u>	d 2 s th an trau			50		500 C			Durtum II.	esperante Trans		2 05/05	
	1 and Health em 27 other tr	8	Randall E. Atkinson 20a. Method of Disposition	/ SOII	20b.	Place of Dispo	osition (N	ame of	Drive, He	Date	20c. Lo	cation - City	or Town, State
و			1XXBurial 2 Cremation 3			cemetery, crei unset Mei		` .	1	2/2005	C.,,	whom loud	. Maryland
altimore,	it. Puriting		4 □ Donation 5 □ Other (Special Signature of ) uneral Service Li						ss of Facility Ad				1
Ba	permit. Page Department Important: Il eny Injury o		1.40	6.1	/	-			r Street,		-		•
<i>&gt;</i>			23a. Part1. Enter the disease, or c	omplications tha	t caused the de	ath. Do not en						Lyrana	Approximate
E .			shock, or heart failure. List of	nly one cause or	each line.	50		3 d d d d d d d d d d d d d d d d d d d	9, 00011 00 001010	- · · · · · · · · · · · · · · · · · · ·	a		Interval Between Onset and Death
10 mg/m	Physician /Medical		disease or condition resulting in death)	a LU	ng (	ance							4 months
	Examiner			○ Due t	o (or <del>as</del> ) a conse	equence of):							
100		e	Sequentially list conditions, if any, leading to immediate	b. Due t	o (or as a conse	equence of):							
	ted nsit		cause. Enter Underlying Cause (Disease or injury			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
•	and al-tra	Examin	that initiated events resulting in death) Last	c. Due!	o (or as a conse	equence of):							
8760	icate be executed physicien and the burial-transit	alE	A Committee of the Comm	e									
287	licate phy: s the	edical		Q			-						
×	The law requires that the death certifiate has been signed by the attending ate has should be detached for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of preg							23d. Date of c	lelivery
.O. Box	atter for (	ciar	in the past 12 months?		e birth 2 ⊟Fe gnant at time of		⊒Ectopic ⊒ Other (	pregnancy specify)				Month	Day Year
o	the d y the iched	ysi	9 Unknown	9□ Unl	known								
Δ.	res that igned b be deta	F P	Part II. Other significant condition	s contributing to	death but not re	esulting in the u	ınderlying	cause give	en in Part I.	23e. Dio	tobacco u	ise contribute	to the cause of death?
gb.	uires sign									10	Yes 2	□ No 3 □	Probably 4 Unknown
Ö	w requir been si should	Completed								24a. Wa	s an	24b. Were	autopsy findings available
Re	he lav	臣								aut per	opsy formed?	prior to	o completion of cause of
ā	ilcian: Th certificate rector, pag		25. Was case referred to medical						26. Place of De		2 ( <b>X</b> No	1 L Y	es 2 No
5	sicia cert rect	o Be	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatie	n, 3[]	Oth	00	dome 5 ☐ Re		€ □Other /€	-00(64)
Division of Vital Records,	ding Physician: The h. h. After this certificate ha funeral director, page	-	27. Manner of Death	28a, Dai	te of Injury	28b. Time o		28c. Injun Work		28d. Describe			oecny)
O	Affer fune	tlor	1. Natural 5 ☐ Pending 2 ☐ Accident investiga		onth, Day Year)	Injury	М		<br Yes 2∐No				
S	dea ctor	fica	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Pla	ce of Injury - At	home, farm, st	reet, fact	ory, office					Rural Route Number,
ă	after Dire	Certification:	4 Homicide	bui	Iding, etc. (Spec	cify)				City or I	own, State	)	
	To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,								ne, date and plac				
	Ne Hc	Medical	(Check only 2 Medical E		basis of exami anner stated.	nation and/or in	vestigati	on, in my o	pinion, death occ	urred at the time	e, date and	l place, and d	ue to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier	1 1			2	9c. License	e number			-	nth, Day, Year)
	3/2		) //il	my	•			ת	36766		No	iembe	1005/25
	-/ 02	4	30. Name and address of person w	no completed ca	ause of death (It	em 23a) (Type,	Print)	<u>U</u>	20700				
	nas		POONAI, VIKRAMA					IVE.	CUMBERLA	ND. MD	21503	2	
1	Sta	ite	31. Date filed (Month, Day, Year)	32	Anistrar's Sig	nature	4						
	Regist	ar	NOV 3 0 2	בטט.	Salita .	D. A	004	1					

		•	1 - For Amend Item 1 - State Registrar	fitate of Marylan	91 <b>,019</b> 1 Cei	2700di tificate	Health and of Death	Mental Hy	rgiene Reg. No. 005	39496
	Physicia	an	1. Decedent's Name (First, Middle, Las					2. Date of De Month	eath Day Yea	3. Time of Death
	/Medic		James Ban	AS JK.				Nov	19 200:	
	Examin	er	4a. Facility Name (If not institution, give			4b. City, 10	wn, or Location of De	ath	4c. County of De	
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1		s. 8. Date of Bi	Wicomic nth 9. E	Birthplace (State or Foreign Country)
	Director		214-30-7668 1	M 2□F	7   Yrs.	Months E	ays Hours Mi	09-11-	1934	MD
and	3.2		Usual Residence of Decedent  10a. State 10b. Cpusty	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
e Maryl	a-f sho	ctor		IERSET C	Risfi	ield	-			1 <b>⊠</b> Yes 2 □ No
Ind 21215-0036 be filed within 72 hours after death with the Maryland	ital Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Mudical Examinar must be notified at	Funeral Director	3/09 Somers (	WE Apt.		10f, Zip Co	2 1817		10g. Citizen of What	Country?
r deat	ems i	ıner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Deceden	t of Hispanic Origin? Cuban, Mexican, Pue	(Specify Yes or No erto Rican, etc.)	o- 14. Race - Ar Black, W	mencan Indian, hite, etc.
<b>036</b> urs afte	al', or it	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 X es 2 No If Yes, Give Year or Dates:   <b>953-</b>		1 ☐ Yes 21€			Specify:	Black
5-0036	natur	Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Dece	dent's Usual C	occupation done during most of w	orking	16b. Kind of Busines	0 1
2121 d within	han "	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.		done during most of we etired)		Somerset	f Education
filed V	Hygier other th	CO	17. Father's Name (First, Middle, Last)			usto	18. Mother's N	ame (First, Middle	Maiden Sumame)	f Education
la be	Mental I arked o atic eve	To Be	James Ban	ks Sr.			Rob		Brow	$\Gamma$
<b>Maryland</b> d 2 should be file	and Mental Hygiene. Is marked other than eumatic event, the M.		19a. Informant's Name/Relationship (7	ype, Print)	logromer.	0	treet and Number or i	Rural Route Numb	er, City or Town, State	
	Health em 27 sther tr		MARY Jackson  20a. Method of Disposition	- +riend	269.		Cove Apt.	CVistic!	d Mb 21 2 c. Location - City	or Town State
altimore,	nent of h		1 ⊠Burial 2 □ Cremation 3 □  '4 □ Donation 5 □ Other (Specify	Removal from State	cemetery crei	natory or other	melly 11-		Mario	1 .
Baltimo permit. Page	Department of Health and Men Important: If Item 27 is marke any injury or other treumatic once.		21. Signature of Funeral Service Licens	100	Ž	Name and	Address of Pility E. Ward	Funeral 1	Home cess Anne,	MD 21853
LO.			23a. Part1. Enter the di ease, or comp	lications that caused the deat						Approximate Interval Between
Ph	ysician		shock, or heart future. List only of Immediate Cause (Final disease or condition	COMPOSITION A	ASTATI		NG CAME	-n		Onset and Death
: ≈ /I	Medical caminer		resulting in death)	a. Due to (or as a conseq		C p.(	140			zyears
	(a) mile	ā	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conseq	uence of):					
petno	dansit	Examiner	Cause (Disease or injury that initiated events	c						
,0°	sician and burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
8760,	physician s the buria	dical		d						
entific	attending p	/Me	IF FEMALE:	23c. If yes, outcome of pregna	ancy				23d. Date of o	delivery
of Vital Records, P.O. Box 68760, Physicien: The law requires that the death certificate be executed	the atter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□Feta 4□Pregnant at time of d 9□Unknown		Ectopic pregi Other (speci			Month	Day Year
, <b>P.O.</b>	igned by the a be detached f		Part II. Other significant conditions co	entributing to death but not res	sulting in the u	nderlying caus	se given in Part I.	23e. Did 1	tobacco use contribute	to the cause of death?
Records,	been sign should be	ed by						12	Yes 2□No 3□	Probably 4 DUnknown
eco law re	as be	Completed						24a. Was	psv prior t	autopsy findings available to completion of cause of
<u>ت</u> ا	this certificate has al director, page 2	Con						perfo	ormed? death	
Vita icien	certifi	Be	25. Was case referred to medical examiner?	Hospital:			Other	eath (Check only		
Phys	r this aral di	To :	1 ☐ Yes 24 No  27. Manner of Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o		Injury at Work?		idence 6 Other (Si how injury occurred	pecify)
Vision	ath. r: Afte e func	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Injury	М	Work? 1 ☐ Yes 2 ☐ No			
÷ 5	after des Directo in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str fy)	eet, factory, o	ffice		Street and Number or wn, State)	Rural Route Number,
Di Hospital or	within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical Co	29a. Certifier 1 Certifying Phyone 2 Medical Examone)	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at vestigation, in	he time, date and pla my opinion, death oc	ce, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
To the	omple	Mec	29b. Signature and title of certifier	and mariner stated.		29c. L	icense number		29d. Date signed (Mo	onth, Day, Year)
<b>-</b>	s - 0		> 2 le Neh			1	057359		November >	10/K 2005
			30. Name and ad 11 ss ol person who d			Print)	538			
			1415. S. Di 31. Date filed (Month, Day, Year) 2. 2	VISION ST,	SALIS	BURY	MD 218	104		
	Sta Registr		31. Date filed (Month, Day, Year) 2 2	2005 Alegistar's Signa	ature #	freek	,			

			1 - For State of Maryland Registrar	/ Department of Health and Mental Hy Certificate of Death	rgiene Reg. № .
	Physic /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  Ruby Jean Bell  4a. Facility Name (If not institution, give street and number)	2. Date of De Month Navent.  4b. City, Town, or Location of Death  Processing Control of Death	Day Year in 1944
	Funeral Director		5. Social Security Number 212-76-0973 6. Sex 1 □ M 2 F 93	t birthday) If Under 1 Year If Under 24 Hrs. B. Date of Bir (Months, Days Hours Min. 10-10-	th ay, Year) 9. Birthplace (State or Foreign Country) Virginia
Ruby Bell CTO C 1314 1-1600	Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-1 show eny injury or other traumetic event, the Medical Evantuar must be rotified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County 10c. City, T  MD Somerset West  10e. Street and Number  9951 Weldon Nelson Lane  11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces? 1	10f. Zip Code   21871   13. Was Decedent of Hispanic Origin? (Specify Yes or Not If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   1	10d. Inside City Limits  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify:  White  16b. Kind of Business/Industry  Own Home  Maiden Sumame)  er, City or Town, State, Zip Code)  Lover, 117, 21871  20c. Location - City or Town, State  Rehobeth, Maryland
	Division of Vital Records, P.O. Box 68760,  Hospital or Attending Physicien: The law requires that the death certificate be executed at hours after death.  Funeral Director: After this certificate has been signed by the attending physician and telly filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	y yath 3⊟Ectopic pregnancy	23d. Date of delivery Month Day Year
	I Records, P.O. I The law requires that the de ate has been signed by the a page 2 should be detached?	Completed by Phys	9 Unknown  Part II. Other significant conditions contributing to death but not resulting	24a. Was auto	psy prior to completion of cause of death?
	Division of Vital Records, I or Attending Physicien: The law requires that after death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	Certification; To Be Co		Injury Wark? M 1 ☐ Yes 2 ☐ No	dence 6 Other (Specify) how injury occurred  Street and Number or Rural Route Number,
*	Div To the Hospital or vithin 24 hours after To the Funaral Direction	edical Cer	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the time, date and place, and due to the n and/or investigation, in my opinion, death occurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To tha complete	Me	29b. Signature and title of certifier  Nu two		29d. Date signed (Month, Day, Year)  11/16/05  .VM MD 21804
	St Regist	ate rar	30. Name and address of person who completed cause of death (Item 23 NOI NATE SAN LL 15 31. Date filed (Month, Day, Year) 32. Registry's Signature NOV 1 8 2005	3a) (Type, Print) 5- DIVISION ST SAUSA	URM MD 21804

Physician /Medical Examiner  1. Decedent's Name (First, Middle, Last)  Orlando Antonio Balea  2. Date of Death Month Day Year 16 Sex 16 Sex 17. Age (In yrs. last birthday)  Funeral Director  Peningular Peningu				1 - For State Registrar	State of Maryla		artment of F <i>rtificate of I</i>			jienę∕ U U lag. No.	5 39498
Principle   Prin				1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	th	3. Time of Death
## PENTANTIAN   Secretary Continued   Secret				Orlando A	Antonio	]	Balea			Day Ye	05 11.45 M
Principle  Principle	V.			4a. Facility Name (If not institution, give	e street and number)			Location of Death			
South Secret Number   Colored   Table   Tabl				Pariosula Pario	and Madical	Carlaa	Salis	6		lalica	24 } 25
County   C		Funeral		5. Social Security Number 4 6. S	ex 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1 9.	Birthplace (State or Foreign
Usual Professional Concentration   100 City, Town or Location   100 City				264-76-3655	ØM 2□F 8	1 Yrs.	Months Days	Hours Min.	April Day	3 <sup>//ea/</sup> 1924	Cuba
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Section   Processing   Proces		ylan		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
Section   Processing   Proces		Ma-f-	ţ	Maryland Wicomio	o S	alisbury	7				1 ☐ Yes 🎇 ☐ No
Section   Processing   Proces		r 28	<u>r</u>						1	0g. Citizen of Wha	t Country?
Section   Processing   Proces		3a o	0	623 Ridge Road			21801			USA	
Section   Processing   Proces		ms 2	era		12. Was Decedent Ever in	U.S. 13.		ispanic Origin? (Sp	pecify Yes or No-		American Indian.
Section   Processing   Proces	36	rs after of the recommendation		1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 📉 No If Yes, Give	ľ				Black, V	Vhite, etc.
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Physician Model as a consequence of the property of the physician state of the physician st	0	of H			Removal from State	cemetery, crei	isition (Name of matory or other plac	θ)	Date	20c. Location - City	or Town, State
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Physician Intelligence Cause (Final disease or or ordinon resulting in death)    Part   Committee Cause (Final disease or or ordinon resulting in death)   Part   Committee Cause (Final disease or or ordinon resulting in death)   Part   Committee Cause (Final disease or or injury that inhibited devents resulting in death)   Last consequence of conseq				23a. Part1. Enter the disease, or com	plications that caused the de						Approximate
Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate any, leading to immediate the property of the standard of white the standard of the property of the property of		Dhycician		Immediate Cause (Final	one cause on each line.		- Eiles	-11.4	4 -		Onset and Death
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The first interest of the state			i i	Sequentially list conditions, if any leading to immediate	b. Due to (or as a cons		fat my				years.
The first interest of the state		ted	Ě	cause. Enter Underlying Cause (Disease or injury	000 10 (01 00 0 00 10	34001.00 01,01					
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building, etc. (specify)  The property of the	8	ath c	an/	23b. Was decedent pregnant	1☐Live birth 2☐F	etal death 3[	Ectopic pregnancy				,
building, etc. (specify)  The property of the		he a	SICI	1 ☐ Yes 2 ☐ No		f death 5	Other (specify)			Month	Day Year
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building, etc. (specify)  The property of the		as the	ρ	Part II. Other significant conditions o	ontributing to death but not i	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribut	e to the cause of death?
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building, etc. (specify)  The property of the	Si	death for: the	cat	E				res 2 No			
29a. Certifier (Check only one)  29b. Signature and title disertifier  29b. Signature and didressof person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  NOV. 21, 2805	<u>≅</u>	or Al fter c lirec in by	듣	data and	286. Place of injury - Al	t home, farm, str <i>icify)</i>	eet, factory, office		28f. Location (Sti City or Town	reet and Number of , State)	Rural Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type Print)  Teffrey Etherton, Nell PRMC, SALISBURY, Mol. 21804		urs a urs a ire [	O								
30. Name and address of person who completed cause of death (Item 23a) (Type Print)  Teffrey Etherton, Nell PRMC, SALISBURY, Mol. 21804		Hosp 4 hou Fune ely fi	cal	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my k ninar: On the basis of exami	nowledge, death	occurred at the time	e, date and place,	and due to the ca	use(s) and manner	r as stated.
30. Name and address of person who completed cause of death (Item 23a) (Type Print)  Teffrey Etherton, Nell PRMC, SALISBURY, Mol. 21804		the I	led	one,	and manner stated.					una piace, and	occionio causo(s)
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Jeffrey Etherton, not, PRINC, SALASBURY, mo. 21804		Os		- WAY	~		1)	76 +83	•	1000. 2	1 1 2005
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an	Decedent's Name (	First, Middle, La	JUN	ישנו	т	BOWMAN		2. Date of D Month	D	ay Ye	3. Fime of B
al	PHYL] 4a. Facility Name (If n			N 15	1		or Location of De			c. County of t	2005 6:3
er			Nursing F	Jomo							
	5. Social Security Num	nber 6.8	Sex 7. Ag	e (In yrs.	last birthday)	If Under 1 Year		irs. 8. Date of B	irth	rince	Georges  Birthplace (State or Country)
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	Usual Residence of D 10a. State 1	ecedent 0b. County		10c. Cit	y, Town or Loc	cation					10d. Inside City
ţ	MD I	Prince	Georges		••		sville				1 □¥es 2
Director	10e. Street and Numb			i		10f. Zip Code			10g. C	itizen of Wha	
a D	5805 Qt	ueen's	Chapel F	24			20782			U.S.	,
Funeral	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.	.S. 13. W	Vas Decedent of F		(Specify Yes or Nerto Rican, etc.)	lo-	14. Race - /	American Indian,
Dy FL	1 Never Married		1 ☐ Yes 2 1			☐ Yes 2☐ No		ento mican, etc.)			White, etc.
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Se C	17. Father's Name (Fit	rst, Middle, Last	")				18. Mother's N	lame (First, Middle	e, Maidei	n Sumame)	
9	Ryan	E. B:	ittner				Ma	ry G. E	Blak	e	
	19a. Informant's Nam	e/Relationship (	Туре, Print)		19b. Mailing	g Address (Street	and Number or	Rural Route Numi	ber, City	or Town, Sta	te, Zip Code)
			father-i				Auth L	ane Sil	ver	Spri	ng,MD209
1	20a. Method of Dispos		Removal from State	20b. P	lace of Dispos emeters, crem	sition (Name of atory or other pla	ce)	Date	20c. L	ocation - City	y or Town, State
	disease or condition resulting in death)	-	a.			HEIMER"	S DISE	ASE			
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Registrar